

**MILITARY COMMISSIONS TRIAL JUDICIARY  
GUANTANAMO BAY, CUBA**

UNITED STATES OF AMERICA

v.

KHALID SHAIKH MOHAMMAD,  
WALID MUHAMMAD SALIH MUBARAK  
BIN 'ATTASH,  
RAMZI BIN AL SHAIBAH,  
AMMAR AL BALUCHI (ALI ABDUL AZIZ  
ALI),  
MUSTAFA AHMED ADAM AL HAWSAWI

AE 038

**JOINT DEFENSE MOTION**

TO CEASE PSYCHOLOGICAL  
DISLOCATION TECHNIQUES AND  
DENIAL OF DETAINEES' RIGHT TO  
DRESS IN THE CLOTHING OF THEIR  
OWN CHOOSING

DATE FILED: 11 May 2012

1. **Timeliness**: This Motion is timely filed under this Court's bench order of 5 May 2012 to file motions for subsequent hearing no later than Saturday, 12 May 2012.
2. **Relief Sought**: The Defense requests that this Court enforce Rule for Military-Commission 804(e) and find that the "accused defense counsel are responsible for ensuring that the accused is properly attired" and requests an order from this Honorable Court as follows: (1) Defense counsel will provide the courtroom attire for their accused immediately prior to any hearing at the Expeditionary Legal Center; (2) Prior to providing the attire to any accused at the Expeditionary Legal Center, JTF-Guantanamo staff at the Expeditionary Legal Center will screen the attire for physical contraband only. If the JTF-Guantanamo staff believes that a particular item may present a force protection concern, this issue shall be brought before the military judge for decision; and (3) JTF-Guantanamo's role in reviewing the courtroom attire is solely limited to screening the items for physical contraband prior to defense counsel providing it to the accused at the Expeditionary Legal Center.
3. **Overview**: Under the circumstances of this case, the accused's right to wear non-prison clothing of their choosing implicates all of the most fundamental aspects of a fair

trial including affording the accused the full benefit of the presumption of innocence, the ability to be fully present, attend and participate in their defense, and – because this is a capital case – to accurately present their persona to the trier of fact.

Joint Task Force (JTF) Guantanamo violated Rule for Military-Commission (RMC) 804(e) and engaged in an arbitrary and capricious action by denying the Accused the right to dress in the clothing of their own choosing. Their actions furthered the C.I.A.'s goal to psychologically dislocate detainees from their individual and social personalities as found in the declassified and redacted IG Report contrary to international standards on the treatment of victims under the Istanbul Protocol. The denial of the opportunity for these alleged combatants to wear items of clothing customarily worn by belligerents within the context of hostilities under the laws of armed conflict reverses the presumption of innocence, and would amount to a *de jure* recognition that the Accused are not lawful combatants.

4. **Burden of Proof:** Under Rule for Military Commission 905(c), the burden of persuasion on any factual issue for the purposes of this Motion is on the Defense as the movant. R.M.C. 905(c)(2). The burden of proof for any factual issue which is necessary to decide this Motion is by a preponderance of the evidence. R.M.C. 905(c)(1).

5. **Statement of Facts**

**Mr. Mohammad's Facts**

A. On or about 3 May 2012, the assistant staff judge advocate for Joint Task Force Guantanamo<sup>3</sup> [REDACTED] advised counsel that if the accused wished to wear their own dress, other than prison attire, for the 5 May 2012 arraignment, then any such clothes must be provided to the assistant staff judge advocate no later than 1200 hours on Friday, 4 May 2012. Attorneys for the assistant judge advocate<sup>3</sup> [REDACTED] inquired why there was practice different from the earlier case in 2008 when defense counsel would

bring the courtroom dress directly the accused at the Expeditionary Legal Center, the assistant staff judge advocate <sup>3</sup> [REDACTED] replied that "this is not 2008." The assistant staff judge advocate informed defense counsel that if the clothes were not provided <sup>3</sup> [REDACTED] by 1200 hours on 4 May 2012, then Mr. Mohammad would only be permitted to wear his prison garments in the courtroom.

B. On or about 0845 hours on 4 May 2012, defense counsel for Mr. Mohammad left both a Pakistani shalwar and kameez for Mr. Mohammad on a hanger and a clear, storage bin with multiple items of clothing for Mr. Mohammad that had been procured by family members and defense counsel. The shalwar and kameez were left in the office of the assistant staff judge advocate <sup>3</sup> [REDACTED] on a hanger and were labeled with Mr. Mohammad's ISN number. The clear, storage bin, also appropriately labeled, included multiple turbans, prayer caps, a black Pakistani vest to be worn over the kameez, and other traditional uniform items that combatants or members of militia would customarily wear under the laws of armed conflict, such as a camouflage vest, a camouflage field jacket, and a camouflage turban.

C. On or about 0900 hours on 5 May 2012, Mr. Mohammad entered the courtroom for the arraignment dressed only in the Pakistan shalwar and kameez provided by his family and defense counsel.

D. Sometime between 0900 hours on 4 May 2012 and 0900 hours on 5 May 2012, the Joint Detention Group commander (COL Donnie L. Thomas) and the JTF-commander (Rear Admiral David B. Woods) decided that no other clothing items were appropriate courtroom attire, maintained possession of Mr. Mohammad's other items and refused to return them to defense counsel that morning. At approximately 0830 hours on 5 May 2012 in the Expeditionary Legal Center, the JDG commander generally refused to answer any questions from defense counsel on why some items were "allowed," and others not allowed,

other than to state that it was “his and the Admiral’s decision.” He also stated that “we’re not going to allow field jackets in the courtroom.” The JDG commander indicated that a western-style suit would be appropriate courtroom attire, and he declined to state whether there was any written policy or directive outlining their authority to make these decisions other than to stay that it was “their call.”

E. On 5 May 2012, The JDG commander was dressed in a camouflage military uniform, as were the approximately 15 guards present in the courtroom, to include the assistant staff judge advocate <sup>3</sup> [REDACTED] All detailed military counsel to the commission wore an appropriate military uniform under the laws of armed conflict.

F. The U.S. Government has declassified and publicly released in a heavily-redacted form some of the facts concerning Mr. Mohammad’s torture at the hands of the U.S. Government in the “IG Report.” (See Attachment B, Declassified and Redacted Central Intelligence Agency, Inspector General Special Review, Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003), 2003-7123-IG (7 May 2004) (General allegations of Mr. Mohammad’s torture, such as the government subjecting him to 183 sessions of waterboarding, have been publicly released and declassified in the instant IG Report).

G. The purpose of the CIA’s program was to psychologically dislocate a detainee:

Captured terrorist turned over to the C.I.A. for interrogation may be subjected to a wide range of . . . techniques. These are designed to **psychologically “dislocate”** the detainee, maximize his feeling of vulnerability and helplessness, and reduce or eliminate his will to resist to obtain crucial intelligence.” (See IG Report, Attachment, B, Appendix F, pg. 1) (Emphasis added).

H. More than 75 experts in law, health and human rights, representing 40 organizations and institutions from 15 countries prepared the “Istanbul Protocol,” a collaborative manual to outline the minimum standards for States in order to “serve as

international guidelines for, *inter alia*, the assessment of persons who allege torture and ill-treatment.” (See Attachment C, Office of the United Nations High Commissioner for Human Rights, Professional Training Series No. 8/Rev.1, *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, pg. 1 (2004).)

I. While the IG Report declares that the *purpose of the CIA’s program* was to “psychologically dislocate” a detainee, the 75 experts in the Istanbul Protocol likewise find that the *purpose of torture* is to disintegrate the individual’s personality:

Perpetrators often attempt to justify their acts of torture and ill-treatment by the need to gather information. Such conceptualizations obscure the purpose of torture and its intended consequences. **One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioural functions. Thus, torture is a means of attacking an individual’s fundamental modes of psychological and social functioning. Under such circumstances, the torturer strives not only to incapacitate a victim physically but also to disintegrate the individual’s personality.** The torturer attempts to destroy a victim’s sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future. By dehumanizing and breaking the will of their victims, torturers set horrific examples for those who later come in contact with the victim. In this way, torture can break or damage the will and coherence of entire communities. In addition, torture can profoundly damage intimate relationships between spouses, parents, children, other family members and relationships between the victims and their communities. (Istanbul Protocol, Attachment C, ¶ 235) (Emphasis added).

J. The 75 experts in the Istanbul Protocol declare that the extreme nature of torture does not occur in a vacuum, but within “the context of personal attribution of meaning, personality development and social, political and cultural factors:”

It is a widely held view that torture is an extraordinary life experience capable of causing a wide range of physical and psychological suffering. Most clinicians and researchers agree that the extreme nature of the torture event is powerful enough on its own to produce mental and emotional consequences, regardless of the individual’s pre-torture psychological status. The psychological consequences of torture, however, occur in the context of personal attribution

of meaning, personality development and social, political and cultural factors. (Istanbul Protocol, Attachment C, ¶ 235).

Mr. al-Baluchi's Facts

K. On or about 4 May 2012, Defense Counsel for Mr. al Baluchi provided to the assistant staff judge advocate <sup>3</sup> [REDACTED] clothes consisting of a Pakistani-style shalwar, kameez, vest, hat, and shoes.

L. Mr. al Baluchi was not wearing the hat and shoes at the arraignment on 5 May. Upon information and belief, Mr. al Baluchi was not allowed to wear the hat and vest by order of the JTF-Guantanamo Commander.

M. Upon information and belief, JTF-Guantanamo was in possession of additional clothing for Mr. al Baluchi that was used during the earlier, 2008 proceedings in this case. JTF-Guantanamo has advised counsel that it does not currently appear to be in possession of these items. The current location of these items is unknown.

N. On 9 May 2012, Defense Counsel for Mr. al Baluchi contacted the assistant staff judge advocate by e-mail <sup>3</sup> [REDACTED] for assistance in resolving these issues, but there has been no response beyond an acknowledgement of receiving the communication.

Mr. Bin al Shibh's Facts

O. On 4 May, 2012, Counsel for Mr. Bin al Shibh delivered to Staff Judge Advocate's office clothing for him to wear at his arraignment which was scheduled for 5 May 2012.

P. This clothing consisted of a tan colored kameez, a tan vest, a traditional Afghan hat and a scarf to be used to fashion a turban.

Q. When Mr. Bin al Shibh entered the courtroom, he was wearing only the kameez. He was prevented from wearing the vest and either of the head gears which had been provided.

R. On 5 May 2012, when I arrived at the courtroom before the arraignment, I was advised that our clients would not be allowed to wear all of the clothing that had been given to them.

S. I approached the JDG commander (COL Thomas), as I was advised that he made the decision on what my client could wear that day. COL Thomas advised me that he was not able to speak with me about any issues concerning my client.

Mr. bin 'Attash's Facts

T. On or about 4 May 2012, Defense Counsel for Mr. bin 'Attash provided to the assistant staff judge advocate<sup>3</sup> [REDACTED] clothes consisting of a Pakistani-style shalwar and kameez, a head scarf, and a camouflage jacket.

U. On 5 May 2012, Mr. bin 'Attash entered the courtroom without his head scarf and camouflage jacket. Upon information and belief, Mr. Bin 'Attash was not allowed to wear the hat and vest by order of the JTF-Guantanamo Commander.

Mr. Hawsawi's Facts

V. On or about 4 May 2012, Defense Counsel for Mr. Hawsawi provided to the assistant staff judge advocate<sup>3</sup> [REDACTED] clothes identified on Attachment E, Clothing Inventory of Mr. Hawsawi.

W. On 5 May 2012, Mr. Hawsawi entered the courtroom without the items provided on Attachment E. Upon information and belief, Mr. Hawsawi was not allowed to certain clothing by order of the JTF-Guantanamo Commander.

X. Mr. Hawsawi's clothes remain missing to date, and a follow up request for information<sup>3</sup> [REDACTED] on 8 May 2012 has been unanswered as of the time of filing.

Arraignment Objections

Y. Counsel at the 5 May 2012 arraignment objected to the actions of JTF-Guantanamo in denying the accused the opportunity to wear clothing of their choice.

Z. The Unofficial/Unauthenticated Transcripts provide at pg 9-12:

DC [Mr. Connell]: James Connell on behalf of Mr. Ali. I'll note in the script the court skipped over the clothing issue. I provided clothing to my client, which included a vest and headgear, and he was not permitted by Joint Task Force-Guantanamo to bring the vest and headgear into court.

MJ [COL Pohl]: Mr. Connell, as I understand that part of the script deals with their prison garb, it was my understanding – correct me if I'm wrong – none of them are in prison garb, they are just not necessarily in the exact civilian clothing – let me rephrase that – exact nonprison garb that you want them in.

DC [Mr. Connell]: That is accurate sir.

MJ [COL Pohl]: For purposes of this hearing, we will continue with that. If that is a real issue, we can address it going forward.

DC [Mr. Nevin]: I would say the same is true with Mr. Mohammad. . .

MJ [COL Pohl]: It strike to me, the rule is they are entitled to wear appropriate nonprison garb attire, and if the JTF Commander makes some arbitrary and capricious decision on that, let me know about it and I will revisit it. That is all I can do at this point.

DC [CPT Schwartz]: If we were told my client can wear a suit, a western American suit but not clothing of his choice, would that be arbitrary and capricious?

MJ [COL Pohl]: I don't give advisory opinions. Just let me know that the issue is. If there is some reason why a certain item of clothing is denied, just because they don't like the style or something like that, that might strike me as arbitrary and capricious.

DC [Mr. Nevin]: Your Honor, David Nevin on behalf of Mr. Mohammad, I spoke to Colonel Thomas this morning about this. He told me that the clothing we provide to Mr. Mohammad would not be allowed, and we asked him respectfully why not. He said, "It is not happening," or words to that effect."

MJ [COL Pohl]: Okay.

DC [Mr. Nevin]: I said, "Is there an SOP? Is there some rule, some standard?" He wouldn't answer the question, told me simply the clothing we provide would not be allowed. The clothing we provided was simply a vest – two vests, actually, Mr. Mohammad could choose from, as well as a turban.

MJ [COL Pohl]: Who is it that told you this?



DC [Mr. Nevin]: Colonel Thomas, Colonel Donnie Thomas. I mean –

MJ [COL Pohl]: I got you. We will get – let me go through this part of it. We will come back to this. It seems to me that is something we can address today at least.

DC [CPT SCHWARTZ] Same issue with Mr. Hawsawi with respect ---

MC [COL POHL]: Mr. Harrington, same thing?

DC [Mr. HARRINGTON]: It is a cultural slash respect thing with the keffiyeh.

MJ [COL POHL]: We will get to it today. If I forget, remind me.

(See Attachment D, KSM II, Unofficial/Unauthenticated Transcript, 5 May 2012).

6. **Legal Authority and Argument.**

**A. JTF-Guantanamo's arbitrary and capricious actions interfered with the duties of counsel and violated Rule for Military-Commission 804(e).**

The Secretary of Defense's Rules for Military-Commission empower the defense counsel and accused with the responsibility for ensuring that the accused is properly attired subject to the military judge's discretion:

R.M.C. 804(e)(1) Appearance and Security of Accused. The accused shall be properly attired in the uniform or dress prescribed by the military judge. The accused and defense counsel are responsible for ensuring that the accused is properly attired; however, upon request, the Joint Task Force Commander or his designee shall render such assistance as may be reasonably necessary to ensure that the accused is properly attired.

The JTF commander and his designee, the JDG commander, superseded the role of defense counsel and accused – absent the request of any accused – by “ensuring” what constitutes proper courtroom attire. JTF-Guantanamo staff overrode the authority of this Court by prescribing what constitutes “proper attire.” JTF-Guantanamo staff interfered with the attorney-client relationship by requiring counsel to present items on Friday, 4 May 2012 under threat of forcing the accused to wear prison garb. When proper attire was provided, JTF-Guantanamo absent a written policy, standard operating procedure, or other

controlling directive, decided to disregard the Secretary of Defense's own Manual for Military Commissions and the jurisdiction of this Court by deciding "what is," and "what isn't," proper courtroom attire.

Notwithstanding this *ultra vires* action, the JDG and JTF commanders must have thought that camouflage was in fact appropriate courtroom attire because the assistant staff judge advocate<sup>3</sup> [REDACTED] the bailiffs, and<sup>2</sup> [REDACTED] guards in the courtroom, wore camouflage uniforms during the 5 May 2012 arraignment. The arbitrary and capricious conduct of JTF-Guantanamo violated the accused's rights under R.M.C. 804(e), interfered with the attorney client relationship, and encroached upon this Court's authority.

**B. Denying the accused their right to wear traditional uniform items that combatants or members of militia would customarily wear under the laws of armed conflict, and which are appropriate courtroom attire for a war crimes court, unconstitutionally diminishes the presumption of innocence.**

The full implementation of the presumption of fairness, which "is a basic component of a fair trial under" any legitimate system of justice, requires courts to "be alert to factors that may undermine the fairness of the fact-finding process." *Estelle v. Williams*, 425 U.S. 501, 503 (1976). One such critical factor is compelling the accused to go to trial in clothing that may undermine the presumption of innocence. *Id.* Because the "defendant's clothing is so likely to be a continuing influence throughout the trial," clothing that dilutes the presumption of innocence creates "an unacceptable risk . . . of impermissible factors coming into play." *Id.* at 505.

The U.S. Government has charged the Accused with violations of the laws of war within the context of hostilities. Hostilities are defined as any conflict subject to the laws of war. 10 U.S.C. § 948a(9). Under the laws of war, combatants are generally required to distinguish themselves from civilians. (*See*, GC III, art. 4; AP 1, art. 44(1)). In charging the

Accused, the U.S. Government contends that their status on the battlefield is that of unprivileged enemy belligerents. Specifically, the Government maintains that they are individuals who: (1) have engaged in hostilities against the U.S., (2) purposefully, and materially supported hostilities, and (3) been part of al Qaeda at the time of the alleged offenses. 10 U.S.C. § 948a(7). A privileged belligerent, on the other hand, “means an individual belonging to one of the eight categories enumerated in Article 4 of the Geneva Convention Relative to the Treatment of Prisoners of War.” *Id.* at § 948a(6). In determining the status of a combatant, the following are the most commonly applied categories of lawful combatants under Article 4(A) of the Third Geneva Convention:

- (1) Members of the armed forces;
- (2) Members of other militias and organized resistance movements provided that they (a) commanded by a person responsible for his subordinates; (b) have a fixed distinctive sign recognizable at a distance; (c) carry their arms openly, and (d) conduct their operations in accordance with the laws and customs of war;
- (3) Members of regular armed forces who profess allegiance to a government;
- (4) Persons who accompany the armed forces without actually being members thereof, such as civilian members of military aircraft crews, war correspondents, supply contractors, etc.;
- (5) Members of crews, including masters, pilots and apprentices, of the merchant marine and the crews of civil aircraft of the Parties to the conflict, etc.; and
- (6) Inhabitants of a non-occupied territory, who on the approach of the enemy spontaneously take up arms to resist the invading forces, without having had time to form themselves into regular armed units, provided they carry arms openly and respect the laws and customs of war.

As a necessary antecedent to their proof, the Government must establish beyond a reasonable doubt that the Accused are not lawful combatants under the laws of war.

Denying any accused before this war crimes court the opportunity to wear appropriate, and respectful uniform items that combatants or members of militia would customarily wear under the laws of armed conflict, such as a camouflage vest, field jacket, and turban directly supports the Government’s proof. JTF-Guantanamo, before the very start of the arraignment, inserted itself into the panel box by deciding – as the factfinder – that the

Accused are not lawful combatants. Consequently, denying the Accused the clothing of his choice, and only permitting them to wear a shalwar and kameez or a western style suit impairs the presumption of innocence.

**C. The arbitrary and capricious policy of JTF-Guantanamo must cease because it furthers the CIA's goal to "psychologically dislocate" detainees contrary to the Istanbul Protocol.**

Because effects of torture can and are designed to alter or obscure an individual's personality, care must be taken to ensure that the accused have every opportunity to appear as the persons they really are, not the persons the government attempted to alter through mistreatment. Particularly in capital cases, an accused has the right to take control of his destiny and to meet the prosecution on his terms. Government action that risks distorting the accused's demeanor are violative of the right to a fair determination of guilt and penalty. *See Riggins v. Nevada*, 504 U.S. 127, 137 (1992). Similarly, capital defendants must be free of any unnecessary "tortures" and "torments" – whether psychological or physical – that interfere with their ability fully to communicate with counsel and participate in his own defense. *Deck v. Missouri*, 544 U.S. 622, 630-31 (2005).

The CIA's program goals as outlined in the IG Report declare that their purpose in the rendition, detention, and interrogation program was to dislocate detainees psychologically. (IG Report, Attachment B, App. F). In 2004, prior to the FOIA release of the IG Report, the 75 experts who drafted the Istanbul Protocol similarly determined that "the torturer strives not only to incapacitate a victim physically but also to disintegrate the individual's personality." (Attachment C, Istanbul Protocol, ¶ 235). As further described in the declassified memoranda of the Office of Legal Counsel the CIA's procedures were designed "to bring the detainee to 'a baseline dependent state,' by 'demonstrat[ing] to [the detainee] that he has no control over basic human needs.'" (Attachment F, U.S. Dept. of Justice, Office of Legal Counsel, dated May 10, 2005, to John A. Rizzo, Senior Deputy General

Counsel, Central Intelligence Agency, re: Continued Use of Certain Techniques in the Interrogation of High Value al Qaeda Detainees, at 54). From the outset of detention, the procedures were intended to make it clear the detainees were under the “complete control of Americans,” and “to underscore ‘the enormity and suddenness in change of environment, the *uncertainty about what will happen next*, and the potential dread [a detained] may have of US custody.” *Id.* at 53 (emphasis added.) The arbitrary, unpredictable and standardless denial of the detainees’ right to wear appropriate clothing, and the disparate treatment afforded American personnel who appeared in military garb, replicated the psychologically disruptive nature of the CIA procedures.

Concerning Mr. Mohammad’s personality, the Government’s own Charge Sheet asserts that Mr. Mohammad was a belligerent from 1996 to 2003 who engaged in hostilities by supporting Usama Bin Laden’s Jihad Against the Americans. (Charge Sheet, pg. 1). Moreover, the Convening Authority redaction of “the Pentagon, Arlington, Virginia” for Charge V: Destruction of Property in Violation of the Law War,” implies that the laws of war permitted the charged Accused, *as a lawful combatant*, to allegedly target the Pentagon as a legitimate military objective. (Charge Sheet, pg. 19). The factual averments in the Charge Sheet as to the other Accused’s conduct, similar to Mr. Mohammad, likewise assert that they were belligerents who engaged in hostilities against the U.S.

By the Government’s own charging decision, they have asserted that the Accused have individual and social personalities as combatants within the context of hostilities. For the purposes of these proceedings, attempts by JTF-Guantanamo to psychologically dislocate the Accused from their personalities as alleged combatants furthers the insidious aim of torturers as declared by the international experts in the Istanbul Protocol.

For the reasons set forth above, the Defense requests that you permit the Accused, subject to a force protection screen for any physical contraband items prior to their

possession of these items in the Expeditionary Legal Center, to dress in the clothes provided by their family and counsel. This would include (a) appropriate cultural dress, such as vests and headgear, and (b) dress that would be customarily worn under the laws of armed conflict, such as a camouflage articles.

7. **Request for Oral Argument:** The Defense requests an oral argument.
8. **Request for Witnesses and the Production of Evidence.**

Under R.M.C. 703, the Defense requests the appearance of:

(a) COL Donnie Thomas, Joint Detention Group Commander, U.S. Naval Station Guantanamo Bay. COL Thomas' testimony is relevant and necessary to establish the facts and circumstances concerning JTF-Guantanamo's decision to disallow the accused to wear the dress of their choice. He is expected to testify that it was "his and the Admiral's call" to decide what the accused would wear in the courtroom, that camouflage items in their opinion is inappropriate, and that western-style clothing is appropriate.

(b) <sup>3</sup> [REDACTED], Assistant Staff Judge Advocate, U.S. Naval Station Guantanamo Bay. <sup>3</sup> [REDACTED] testimony is relevant and necessary to establish the facts and circumstances concerning JTF-Guantanamo's decision to disallow the accused to wear the dress of their choice. <sup>3</sup> [REDACTED] expected to testify that <sup>3</sup> [REDACTED] received instruction to inform defense counsel that JTF-Guantanamo would compel the accused to wear prison garb at the arraignment if the defense counsel did not comply with instructions from JTF-Guantanamo to submit the clothes for a review.

Under R.M.C. 703, The defense reserves the right to add additional witnesses as its investigation develops. For instance, while the defense has briefly interviewed both COL Thomas <sup>3</sup> [REDACTED] as to the facts for this Motion, the defense has been unable to interview Rear Admiral David Woods in person.

Under R.M.C., the defense requests the production of the following documentary evidence for the purposes of this Motion:

- (a) Any and all communications and related writings (electronic or otherwise) concerning a JTF-Guantanamo policy on the wear of courtroom attire. This information is relevant and necessary to ascertain the scope of the Governmental interference with respect to RMC 804(e).
- (b) Any communications and related writings between any trial counsel and any member of JTF-Guantanamo staff concerning detainee courtroom attire. This

information is relevant and necessary to ascertain the scope of the Governmental interference with respect to RMC 804(e).

9. **Conference with Opposing Counsel:** The defense has attempted to confer with the prosecution several times on 10 and 11 May 2012 regarding this issue, and as of filing, the prosecution has not indicated whether they oppose the instant Motion.

10. **Attachments:**

A. Certificate of Service (1 page).

B. Declassified and Redacted Central Intelligence Agency, Inspector General *Special Review, Counterterrorism Detention and Interrogation Activities* (September 2001 – October 2003), 2003-7123-IG (7 May 2004).

C. Office of the United Nations High Commissioner for Human Rights, Professional Training Series No. 8/Rev.1, *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (2004).

D. Portion of Unofficial/Unauthenticated Transcript, U.S. v. Khalid Shiakh Mohammad, et al., arraignment hearing, (5 May 2012).

E. Mr. Hawsawi's Clothing Inventory.

F. U.S. Dept. of Justice, Office of Legal Counsel, dated May 10, 2005, to John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, re: Continued Use of Certain Techniques in the Interrogation of High Value al Qaeda Detainees

Respectfully submitted,

//s//  
DAVID Z. NEVIN  
Learned Counsel

//s//  
DEREK A. POTEET  
Maj, USMC  
Defense Counsel

//s//  
JASON D. WRIGHT  
CPT, USA, JAGC  
Defense Counsel

*Counsel for Mr. Mohammad*

//s//

JAMES G. CONNELL, III  
Detailed Learned Counsel

*Counsel for Mr. al Baluchi*

//s//

STERLING R. THOMAS  
Lt Col, USAF  
Detailed Military Defense Counsel

//s//

JAMES P. HARRINGTON  
Learned Counsel

*Counsel for Mr. bin al Shibh*

//s//

KEVIN BOGUCKI  
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//s//

CHERYL T. BORMANN  
Learned Counsel

//s//

WILLIAM T. HENNESSY  
Maj, USMC  
Defense Counsel

//s//

MICHAEL A. SCHWARTZ  
Capt, USAF  
Defense Counsel

*Counsel for Mr. bin 'Attash*

//s//

WALTER V. RUIZ  
CDR, USN  
Defense Counsel

*Counsel for Mr. Hawsawi*



**MILITARY COMMISSIONS TRIAL JUDICIARY  
GUANTANAMO BAY, CUBA**

UNITED STATES OF AMERICA

v.

KHALID SHAIKH MOHAMMAD,  
WALID MUHAMMAD SALIH MUBARAK  
BIN 'ATTASH,  
RAMZI BIN AL SHAIBAH,  
AMMAR AL BALUCHI (ALI ABDUL AZIZ  
ALI),  
MUSTAFA AHMED ADAM AL HAWSAWI

AE \_\_\_\_

**ORDER**

DATE

The Military-Commission has considered the JOINT DEFENSE MOTION TO  
CEASE PSYCHOLOGICAL DISLOCATION TECHNIQUES AND DENIAL OF  
DETAINEES' RIGHT TO DRESS IN THE CLOTHING OF THEIR OWN CHOOSING, and  
any Responses, and Replies thereto, and hereby **FINDS** that the counsel and accused are  
responsible for ensuring that the accused are properly attired subject to the discretion of  
the Military Judge.

It is **HEREBY ORDERED**:

- (1) Defense counsel will provide the courtroom attire for their accused immediately prior to any hearing at the Expeditionary Legal Center;
- (2) Prior to providing the attire to any accused at the Expeditionary Legal Center, JTF-Guantanamo staff at the Expeditionary Legal Center will screen the attire for physical contraband only. If the JTF-Guantanamo staff believes that a particular item may present a force protection concern, this issue shall be brought before the military judge for decision.
- (3) JTF-Guantanamo's role in reviewing the courtroom attire is solely limited to screening the items for physical contraband prior to defense counsel providing it to the accused at the Expeditionary Legal Center.

Signed, this \_\_\_\_ day of \_\_\_\_ 2012.

\_\_\_\_\_  
JAMES L. POHL  
COL, USA, JAGC  
Military Judge

**CERTIFICATE OF SERVICE**

I certify that on the 11th day of May, 2012, I electronically filed the foregoing document with the Clerk of the Court and served the foregoing on all counsel of record by e-mail.

*//s//*

Jason D. Wright  
CPT, USA, JAGC  
*Defense Counsel*

~~TOP SECRET~~ [REDACTED]

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*Central Intelligence Agency  
Inspector General*

# SPECIAL REVIEW



(TS [REDACTED]) COUNTERTERRORISM DETENTION AND  
INTERROGATION ACTIVITIES  
(SEPTEMBER 2001 – OCTOBER 2003)  
(2003-7123-IG)

7 May 2004

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OFFICE OF INSPECTOR GENERAL

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INTRODUCTION

1. [REDACTED]

2. (TS [REDACTED]) In November 2002, the Deputy Director for Operations (DDO) informed the Office of Inspector General (OIG) that the Agency had established a program in the Counterterrorist Center to detain and interrogate terrorists at sites abroad ("the CTC Program"). He also informed OIG that he had just learned of and had dispatched a team to investigate [REDACTED]

[REDACTED] In January 2003, the DDO informed OIG that he had received allegations that Agency personnel had used unauthorized interrogation techniques with a detainee, 'Abd Al-Rahim Al-Nashiri, at another foreign site, and requested that

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OIG investigate. Separately, OIG received information that some employees were concerned that certain covert Agency activities at an overseas detention and interrogation site might involve violations of human rights. In January 2003, OIG initiated a review of Agency counterterrorism detention and interrogation activities [REDACTED] and the incident with Al-Nashiri.<sup>1</sup> This Review covers the period September 2001 to mid-October 2003.<sup>2</sup> [REDACTED]

## SUMMARY

3. (TS) [REDACTED]

[REDACTED] the DCI assigned responsibility for implementing capture and detention authority to the DDO and to the Director of the DCI Counterterrorist Center (D/CTC). When U.S. military forces began detaining individuals in Afghanistan and at Guantanamo Bay, Cuba, [REDACTED]

4. (TS) [REDACTED]

[REDACTED] the Agency began to detain and interrogate directly a number of suspected terrorists. The capture and initial Agency interrogation of the first high value detainee, Abu Zubaydah,

<sup>1</sup> (S) [REDACTED] (NF) Appendix A addresses the Procedures and Resources that OIG employed in conducting this Review. The Review does not address renditions conducted by the Agency or interrogations conducted jointly with [REDACTED] the U.S. military.

<sup>2</sup> (U) Appendix B is a chronology of significant events that occurred during the period of this Review.

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in March 2002, presented the Agency with a significant dilemma.<sup>4</sup> The Agency was under pressure to do everything possible to prevent additional terrorist attacks. Senior Agency officials believed Abu Zubaydah was withholding information that could not be obtained through then-authorized interrogation techniques. Agency officials believed that a more robust approach was necessary to elicit threat information from Abu Zubaydah and possibly from other senior Al-Qa'ida high value detainees.

5. (TS [REDACTED]) The conduct of detention and interrogation activities presented new challenges for CIA. These included determining where detention and interrogation facilities could be securely located and operated, and identifying and preparing qualified personnel to manage and carry out detention and interrogation activities. With the knowledge that Al-Qa'ida personnel had been trained in the use of resistance techniques, another challenge was to identify interrogation techniques that Agency personnel could lawfully use to overcome the resistance. In this context, CTC, with the assistance of the Office of Technical Service (OTS), proposed certain more coercive physical techniques to use on Abu Zubaydah. All of these considerations took place against the backdrop of pre-September 11, 2001 CIA avoidance of interrogations and repeated U.S. policy statements condemning torture and advocating the humane treatment of political prisoners and detainees in the international community.

6. (TS [REDACTED]) The Office of General Counsel (OGC) took the lead in determining and documenting the legal parameters and constraints for interrogations. OGC conducted independent research

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<sup>4</sup> (TS [REDACTED]) The use of "high value" or "medium value" to describe terrorist targets and detainees in this Review is based on how they have been generally categorized by CTC. CTC distinguishes targets according to the quality of the intelligence that they are believed likely to be able to provide about current terrorist threats against the United States. Senior Al-Qa'ida planners and operators, such as Abu Zubaydah and Khalid Shaykh Muhammad, fall into the category of "high value" and are given the highest priority for capture, detention, and interrogation. CTC categorizes those individuals who are believed to have lesser direct knowledge of such threats, but to have information of intelligence value, as "medium value" targets/detainees.

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and consulted extensively with Department of Justice (DoJ) and National Security Council (NSC) legal and policy staff. Working with DoJ's Office of Legal Counsel (OLC), OGC determined that in most instances relevant to the counterterrorism detention and interrogation activities [REDACTED] the criminal prohibition against torture, 18 U.S.C. 2340-2340B, is the controlling legal constraint on interrogations of detainees outside the United States. In August 2002, DoJ provided to the Agency a legal opinion in which it determined that 10 specific "Enhanced Interrogation Techniques" (EITs) would not violate the torture prohibition. This work provided the foundation for the policy and administrative decisions that guide the CTC Program.

7. (TS [REDACTED]) By November 2002, the Agency had Abu Zubaydah and another high value detainee, 'Abd Al-Rahim Al-Nashiri, in custody [REDACTED]

[REDACTED] and the Office of Medical Services (OMS) provided medical care to the detainees.

8. [REDACTED]

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9. (TS) [REDACTED]

[REDACTED] From the beginning, OGC briefed DO officers assigned to these [REDACTED] facilities on their legal authorities, and Agency personnel staffing these facilities documented interrogations and the condition of detainees in cables.

10. (TS) [REDACTED] There were few instances of deviations from approved procedures [REDACTED] with one notable exception described in this Review. With respect to two detainees at those sites, the use and frequency of one EIT, the waterboard, went beyond the projected use of the technique as originally described to DoJ. The Agency, on 29 July 2003, secured oral DoJ concurrence that certain deviations are not significant for purposes of DoJ's legal opinions.

11. [REDACTED]

12. [REDACTED]

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~~TOP SECRET/~~ [REDACTED]13. [REDACTED]  
[REDACTED]  
[REDACTED] there were instances of improvisation and other undocumented interrogation techniques [REDACTED]  
[REDACTED]14. [REDACTED]  
[REDACTED]

15. (TS, [REDACTED]) Agency efforts to provide systematic, clear and timely guidance to those involved in the CTC Detention and Interrogation Program was inadequate at first but have improved considerably during the life of the Program as problems have been identified and addressed. CTC implemented training programs for interrogators and debriefers.<sup>6</sup> Moreover, building upon operational and legal guidance previously sent to the field, the DCI

<sup>6</sup> (TS, [REDACTED]) Before 11 September (9/11) 2001, Agency personnel sometimes used the terms *interrogation/interrogator* and *debriefing/debriefer* interchangeably. The use of these terms has since evolved and, today, CTC more clearly distinguishes their meanings. A debriefer engages a detainee solely through question and answer. An interrogator is a person who completes a two-week interrogations training program, which is designed to train, qualify, and certify a person to administer EITs. An interrogator can administer EITs during an interrogation of a detainee only after the field, in coordination with Headquarters, assesses the detainee as withholding information. An interrogator transitions the detainee from a non-cooperative to a cooperative phase in order that a debriefer can elicit actionable intelligence through non-aggressive techniques during debriefing sessions. An interrogator may debrief a detainee during an interrogation; however, a debriefer may not interrogate a detainee.

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on 28 January 2003 signed "Guidelines on Confinement Conditions for CIA Detainees" and "Guidelines on Interrogations Conducted Pursuant [REDACTED]"

[REDACTED] The DCI Guidelines require individuals engaged in or supporting interrogations [REDACTED] be made aware of the guidelines and sign an acknowledgment that they have read them. The DCI Interrogation Guidelines make formal the existing CTC practice of requiring the field to obtain specific Headquarters approvals prior to the application of all EITs. Although the DCI Guidelines are an improvement over the absence of such DCI Guidelines in the past, they still leave substantial room for misinterpretation and do not cover all Agency detention and interrogation activities.

16. (TS [REDACTED]) The Agency's detention and interrogation of terrorists has provided intelligence that has enabled the identification and apprehension of other terrorists and warned of terrorist plots planned for the United States and around the world. The CTC Program has resulted in the issuance of thousands of individual intelligence reports and analytic products supporting the counterterrorism efforts of U.S. policymakers and military commanders.

17. (TS [REDACTED]) The current CTC Detention and Interrogation Program has been subject to DoJ legal review and Administration approval but diverges sharply from previous Agency policy and rules that govern interrogations by U.S. military and law enforcement officers. Officers are concerned that public revelation of the CTC Program will seriously damage Agency officers' personal reputations, as well as the reputation and effectiveness of the Agency itself.

18. (TS [REDACTED]) recognized that detainees may be held in U.S. Government custody indefinitely if appropriate law enforcement jurisdiction is not asserted. Although there has been ongoing discussion of the issue inside the Agency and among NSC,

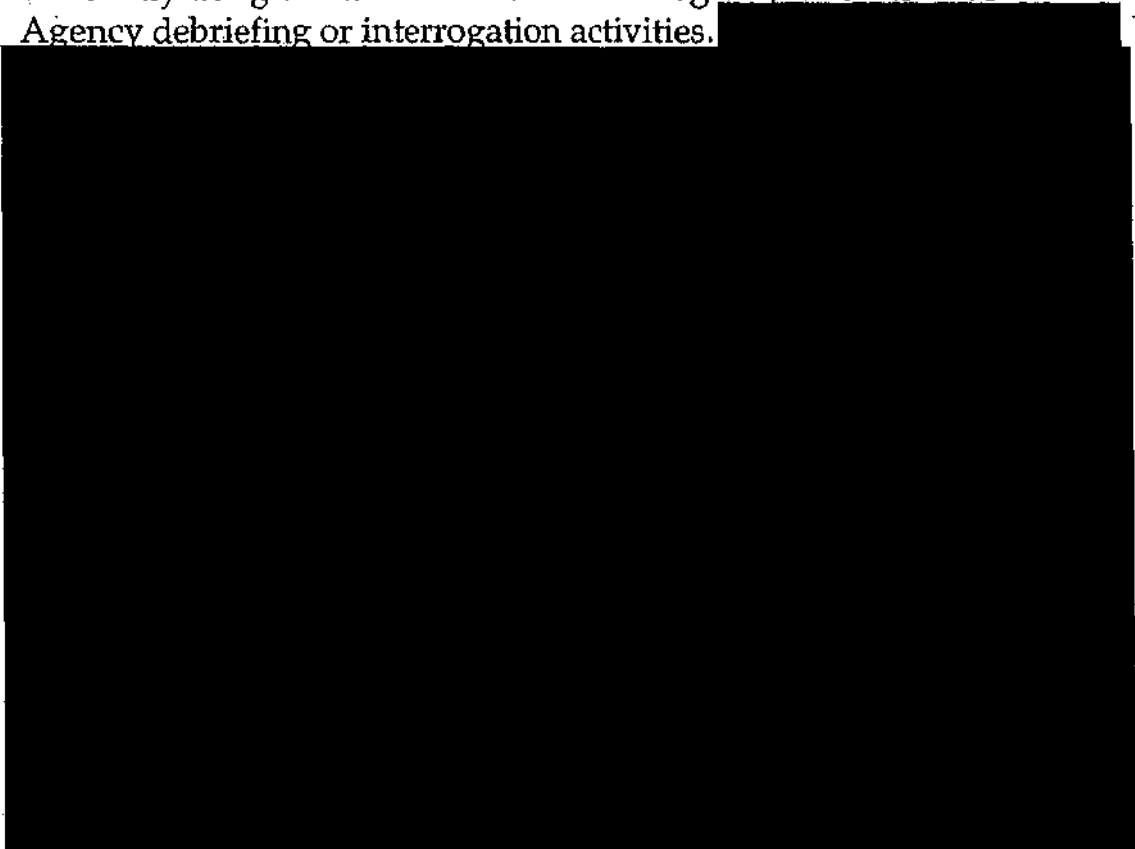
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Defense Department, and Justice Department officials, no decisions on any "endgame" for Agency detainees have been made. Senior Agency officials see this as a policy issue for the U.S. Government rather than a CIA issue. Even with Agency initiatives to address the endgame with policymakers, some detainees who cannot be prosecuted will likely remain in CIA custody indefinitely.

19. (TS [REDACTED]) The Agency faces potentially serious long-term political and legal challenges as a result of the CTC Detention and Interrogation Program, particularly its use of EITs and the inability of the U.S. Government to decide what it will ultimately do with terrorists detained by the Agency.

20. (TS [REDACTED]) This Review makes a number of recommendations that are designed to strengthen the management and conduct of Agency detention and interrogation activities. Although the DCI Guidelines were an important step forward, they were only designed to address the CTC Program, rather than all Agency debriefing or interrogation activities.

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21. [REDACTED]

## BACKGROUND

22. (S) The Agency has had intermittent involvement in the interrogation of individuals whose interests are opposed to those of the United States. After the Vietnam War, Agency personnel experienced in the field of interrogations left the Agency or moved to other assignments. In the early 1980s, a resurgence of interest in teaching interrogation techniques developed as one of several methods to foster foreign liaison relationships. Because of political sensitivities the then-Deputy Director of Central Intelligence (DDCI) forbade Agency officers from using the word "interrogation." The Agency then developed the Human Resource Exploitation (HRE) training program designed to train foreign liaison services on interrogation techniques.

23. (S) In 1984, OIG investigated allegations of misconduct on the part of two Agency officers who were involved in interrogations and the death of one individual [REDACTED]. Following that investigation, the Agency took steps to ensure Agency personnel understood its policy on

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interrogations, debriefings, and human rights issues. Headquarters sent officers to brief Stations and Bases and provided cable guidance to the field.

24. (S) In 1986, the Agency ended the HRE training program because of allegations of human rights abuses in Latin America.

[REDACTED] DO Handbook [REDACTED]  
which remains in effect, explains the Agency's general interrogation policy:

[REDACTED]

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## DISCUSSION

GENESIS OF POST 9/11 AGENCY DETENTION AND INTERROGATION  
ACTIVITIES

25. (TS [REDACTED]) The statutory basis for CIA's involvement in detentions and interrogations is [REDACTED] the National Security Act of 1947, as amended.<sup>7</sup>

[REDACTED]

26. (TS [REDACTED])

[REDACTED]

27. (S//NF) The DCI delegated responsibility for implementation [REDACTED] to the DDO and D/CTC. Over time, CTC also solicited assistance from other Agency components, including OGC, OMS, [REDACTED] and OTS.

<sup>7</sup> ~~(TS//FOUO)~~ DoJ takes the position that as Commander-in-Chief, the President independently has the Article II constitutional authority to order the detention and interrogation of enemy combatants to gain intelligence information.

8 [REDACTED]

9 [REDACTED]

10 [REDACTED]

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28. (TS [REDACTED]) To assist Agency officials in understanding the scope and implications [REDACTED] [REDACTED] OGC researched, analyzed, and wrote "draft" papers on multiple legal issues. These included discussions of the [REDACTED]

[REDACTED] OGC shared these "draft" papers with Agency officers responsible [REDACTED]

29. [REDACTED]

#### *THE CAPTURE OF ABU ZUBAYDAH AND DEVELOPMENT OF EITS*

30. (TS [REDACTED]) The capture of senior Al-Qa'ida operative Abu Zubaydah on 27 March 2002 presented the Agency with the opportunity to obtain actionable intelligence on future threats to the United States from the most senior Al-Qa'ida member in U.S. custody at that time. This accelerated CIA's development of an interrogation program [REDACTED]

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[REDACTED]

31. (TS [REDACTED]) To treat the severe wounds that Abu Zubaydah suffered upon his capture, the Agency provided him intensive medical care from the outset and deferred his questioning for several weeks pending his recovery. The Agency then assembled a team that interrogated Abu Zubaydah using non-aggressive, non-physical elicitation techniques. [REDACTED]

[REDACTED] The Agency believed that Abu Zubaydah was withholding imminent threat information.

32. (TS [REDACTED]) Several months earlier, in late 2001, CIA had tasked an independent contractor psychologist, who had [REDACTED] experience in the U.S. Air Force's Survival, Evasion, Resistance, and Escape (SERE) training program, to research and write a paper on Al-Qa'ida's resistance to interrogation techniques.<sup>13</sup> This psychologist collaborated with a Department of Defense (DoD) psychologist who had [REDACTED] SERE experience in the U.S. Air Force and DoD to produce the paper, "Recognizing and Developing Countermeasures to Al-Qa'ida Resistance to Interrogation Techniques: A Resistance Training Perspective." Subsequently, the two psychologists developed a list of new and more aggressive EITs that they recommended for use in interrogations.

12 [REDACTED]

13 (U//FOUO) The SERE training program falls under the DoD Joint Personnel Recovery Agency (JPRA). JPRA is responsible for missions to include the training for SERE and Prisoner of War and Missing In Action operational affairs including repatriation. SERE Training is offered by the U.S. Army, Navy, and Air Force to its personnel, particularly air crews and special operations forces who are of greatest risk of being captured during military operations. SERE students are taught how to survive in various terrain, evade and endure captivity, resist interrogations, and conduct themselves to prevent harm to themselves and fellow prisoners of war.

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33. (TS/ [REDACTED]) CIA's OTS obtained data on the use of the proposed EITs and their potential long-term psychological effects on detainees. OTS input was based in part on information solicited from a number of psychologists and knowledgeable academics in the area of psychopathology.

34. (TS/ [REDACTED]) OTS also solicited input from DoD/Joint Personnel Recovery Agency (JPRA) regarding techniques used in its SERE training and any subsequent psychological effects on students. DoD/JPRA concluded no long-term psychological effects resulted from use of the EITs, including the most taxing technique, the waterboard, on SERE students.<sup>14</sup> The OTS analysis was used by OGC in evaluating the legality of techniques.

35. (TS/ [REDACTED]) Eleven EITs were proposed for adoption in the CTC Interrogation Program. As proposed, use of EITs would be subject to a competent evaluation of the medical and psychological state of the detainee. The Agency eliminated one proposed technique—[REDACTED]—after learning from DoJ that this could delay the legal review. The following textbox identifies the 10 EITs the Agency described to DoJ.

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<sup>14</sup> (S) According to individuals with authoritative knowledge of the SERE program, the waterboard was used for demonstration purposes on a very small number of students in a class. Except for Navy SERE training, use of the waterboard was discontinued because of its dramatic effect on the students who were subjects.

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### Enhanced Interrogation Techniques

- ♦ The **attention grasp** consists of grasping the detainee with both hands, with one hand on each side of the collar opening, in a controlled and quick motion. In the same motion as the grasp, the detainee is drawn toward the interrogator.
- ♦ During the walling technique, the detainee is pulled forward and then quickly and firmly pushed into a flexible false wall so that his shoulder blades hit the wall. His head and neck are supported with a rolled towel to prevent whiplash.
- ♦ The **facial hold** is used to hold the detainee's head immobile. The interrogator places an open palm on either side of the detainee's face and the interrogator's fingertips are kept well away from the detainee's eyes.
- ♦ With the facial or insult slap, the fingers are slightly spread apart. The interrogator's hand makes contact with the area between the tip of the detainee's chin and the bottom of the corresponding earlobe.
- ♦ In **cramped confinement**, the detainee is placed in a confined space, typically a small or large box, which is usually dark. Confinement in the smaller space lasts no more than two hours and in the larger space it can last up to 18 hours.
- ♦ Insects placed in a confinement box involve placing a harmless insect in the box with the detainee.
- ♦ During **wall standing**, the detainee may stand about 4 to 5 feet from a wall with his feet spread approximately to his shoulder width. His arms are stretched out in front of him and his fingers rest on the wall to support all of his body weight. The detainee is not allowed to reposition his hands or feet.
- ♦ The application of stress positions may include having the detainee sit on the floor with his legs extended straight out in front of him with his arms raised above his head or kneeling on the floor while leaning back at a 45 degree angle.
- ♦ **Sleep deprivation** will not exceed 11 days at a time.
- ♦ The application of the waterboard technique involves binding the detainee to a bench with his feet elevated above his head. The detainee's head is immobilized and an interrogator places a cloth over the detainee's mouth and nose while pouring water onto the cloth in a controlled manner. Airflow is restricted for 20 to 40 seconds and the technique produces the sensation of drowning and suffocation.

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## DOJ LEGAL ANALYSIS

36. ~~(TS)~~ [REDACTED] CIA's OGC sought guidance from DoJ regarding the legal bounds of EITs vis-à-vis individuals detained [REDACTED]. The ensuing legal opinions focus on the Convention Against Torture and Other Cruel, Inhumane and Degrading Treatment or Punishment (Torture Convention),<sup>15</sup> especially as implemented in the U.S. criminal code, 18 U.S.C. 2340-2340A.

37. ~~(U//FOUO)~~ The Torture Convention specifically prohibits "torture," which it defines in Article 1 as:

any act by which *severe* pain or suffering, whether physical or mental, is *intentionally* inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanction. [Emphasis added.]

Article 4 of the Torture Convention provides that states party to the Convention are to ensure that all acts of "torture" are offenses under their criminal laws. Article 16 additionally provides that each state party "shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to acts of torture as defined in Article 1."

<sup>15</sup> ~~(U//FOUO)~~ Adopted 10 December 1984, S. Treaty Doc. No. 100-20 (1988) 1465 U.N.T.S. 85 (entered into force 26 June 1987). The Torture Convention entered into force for the United States on 20 November 1994.

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38. ~~(U//FOUO)~~ The Torture Convention applies to the United States only in accordance with the reservations and understandings made by the United States at the time of ratification.<sup>16</sup> As explained to the Senate by the Executive Branch prior to ratification:

Article 16 is arguably broader than existing U.S. law. The phrase "cruel, inhuman or degrading treatment or punishment" is a standard formula in international instruments and is found in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the European Convention on Human Rights. To the extent the phrase has been interpreted in the context of those agreements, "cruel" and "inhuman" treatment or punishment appears to be roughly equivalent to the treatment or punishment barred in the United States by the Fifth, Eighth and Fourteenth Amendments. "Degrading" treatment or punishment, however, has been interpreted as potentially including treatment that would probably not be prohibited by the U.S. Constitution. [Citing a ruling that German refusal to recognize individual's gender change might be considered "degrading" treatment.] To make clear that the United States construes the phrase to be coextensive with its constitutional guarantees against cruel, unusual, and inhumane treatment, the following understanding is recommended:

"The United States understands the term 'cruel, inhuman or degrading treatment or punishment,' as used in Article 16 of the Convention, to mean the cruel, unusual, and inhumane treatment or punishment prohibited by the Fifth, Eighth and/or Fourteenth Amendments to the Constitution of the United States."<sup>17</sup> [Emphasis added.]

<sup>16</sup> (U) Vienna Convention on the Law of Treaties, 23 May 1969, 1155 U.N.T.S. 331 (entered into force 27 January 1980). The United States is not a party to the Vienna Convention on treaties, but it generally regards its provisions as customary international law.

<sup>17</sup> ~~(U//FOUO)~~ S. Treaty Doc. No. 100-20, at 15-16.

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39. ~~(U//FOUO)~~ In accordance with the Convention, the United States criminalized acts of torture in 18 U.S.C. 2340A(a), which provides as follows:

Whoever outside the United States commits or attempts to commit torture shall be fined under this title or imprisoned not more than 20 years, or both, and if death results to any person from conduct prohibited by this subsection, shall be punished by death or imprisoned for any term of years or for life.

The statute adopts the Convention definition of "torture" as "an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control."<sup>18</sup> "Severe physical pain and suffering" is not further defined, but Congress added a definition of "severe mental pain or suffering:"

[T]he prolonged mental harm caused by or resulting from—

- (A) the intentional infliction or threatened infliction of severe physical pain or suffering;
- (B) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality;
- (C) the threat of imminent death; or
- (D) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality. . . .<sup>19</sup>

These statutory definitions are consistent with the understandings and reservations of the United States to the Torture Convention.

<sup>18</sup> ~~(U//FOUO)~~ 18 U.S.C. 2340(1).

<sup>19</sup> ~~(U//FOUO)~~ 18 U.S.C. 2340(2).

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40. ~~(U//FOUO)~~ DoJ has never prosecuted a violation of the torture statute, 18 U.S.C. §2340, and there is no case law construing its provisions. OGC presented the results of its research into relevant issues under U.S. and international law to DoJ's OLC in the summer of 2002 and received a preliminary summary of the elements of the torture statute from OLC in July 2002. An unclassified 1 August 2002 OLC legal memorandum set out OLC's conclusions regarding the proper interpretation of the torture statute and concluded that "Section 2340A proscribes acts inflicting, and that are specifically intended to inflict, severe pain or suffering whether mental or physical."<sup>20</sup> Also, OLC stated that the acts must be of an "extreme nature" and that "certain acts may be cruel, inhuman, or degrading, but still not produce pain and suffering of the requisite intensity to fall within Section 2340A's proscription against torture." Further describing the requisite level of intended pain, OLC stated:

Physical pain amounting to torture must be equivalent in intensity to the pain accompanying serious physical injury, such as organ failure, impairment of bodily function, or even death. For purely mental pain or suffering to amount to torture under Section 2340, it must result in significant psychological harm of significant duration, e.g., lasting for months or even years.<sup>21</sup>

OLC determined that a violation of Section 2340 requires that the infliction of severe pain be the defendant's "precise objective." OLC also concluded that necessity or self-defense might justify interrogation methods that would otherwise violate Section 2340A.<sup>22</sup> The August 2002 OLC opinion did not address whether any other provisions of U.S. law are relevant to the detention, treatment, and interrogation of detainees outside the United States.<sup>23</sup>

<sup>20</sup> ~~(U//FOUO)~~ Legal Memorandum, Re: Standards of Conduct for Interrogation under 18 U.S.C. 2340-2340A (1 August 2002).

<sup>21</sup> ~~(U//FOUO)~~ Ibid., p. 1.

<sup>22</sup> ~~(U//FOUO)~~ Ibid., p. 39.

<sup>23</sup> ~~(U//FOUO)~~ OLC's analysis of the torture statute was guided in part by judicial decisions under the Torture Victims Protection Act (TVPA) 28 U.S.C. 1350, which provides a tort remedy for victims of torture. OLC noted that the courts in this context have looked at the entire course

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~~TOP SECRET~~ [REDACTED]

41. ~~(U//FOUO)~~ A second unclassified 1 August 2002 OLC opinion addressed the international law aspects of such interrogations.<sup>24</sup> This opinion concluded that interrogation methods that do not violate 18 U.S.C. 2340 would not violate the Torture Convention and would not come within the jurisdiction of the International Criminal Court.

42. ~~(TS)~~ [REDACTED] In addition to the two unclassified opinions, OLC produced another legal opinion on 1 August 2002 at the request of CIA.<sup>25</sup> (Appendix C.) This opinion, addressed to CIA's Acting General Counsel, discussed whether the proposed use of EITs in interrogating Abu Zubaydah would violate the Title 18 prohibition on torture. The opinion concluded that use of EITs on Abu Zubaydah would not violate the torture statute because, among other things, Agency personnel: (1) would not specifically intend to inflict severe pain or suffering, and (2) would not in fact inflict severe pain or suffering.

43. ~~(TS)~~ [REDACTED] This OLC opinion was based upon specific representations by CIA concerning the manner in which EITs would be applied in the interrogation of Abu Zubaydah. For example, OLC was told that the EIT "phase" would likely last "no more than several days but could last up to thirty days." The EITs would be used on "an as-needed basis" and all would not necessarily be used. Further, the EITs were expected to be used "in some sort of escalating fashion, culminating with the waterboard though not necessarily ending with this technique." Although some of the EITs

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of conduct, although a single incident could constitute torture. OLC also noted that courts may be willing to find a wide range of physical pain can rise to the level of "severe pain and suffering." Ultimately, however, OLC concluded that the cases show that only acts "of an extreme nature have been redressed under the TVPA's civil remedy for torture." White House Counsel Memorandum at 22 - 27.

<sup>24</sup> ~~(U//FOUO)~~ OLC Opinion by John C. Yoo, Deputy Assistant Attorney General, OLC (1 August 2002).

<sup>25</sup> ~~(TS)~~ [REDACTED] Memorandum for John Rizzo, Acting General Counsel of the Central Intelligence Agency, "Interrogation of al Qaida Operative" (1 August 2002) at 15.

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~~TOP SECRET~~/ [REDACTED]

might be used more than once, "that repetition will not be substantial because the techniques generally lose their effectiveness after several repetitions." With respect to the waterboard, it was explained that:

... the individual is bound securely to an inclined bench . . . . The individual's feet are generally elevated. A cloth is placed over the forehead and eyes. Water is then applied to the cloth in a controlled manner. As this is done, the cloth is lowered until it covers both the nose and mouth. Once the cloth is saturated and completely covers the mouth and nose, the air flow is slightly restricted for 20 to 40 seconds due to the presence of the cloth. This causes an increase in carbon dioxide level in the individual's blood. This increase in the carbon dioxide level stimulates increased effort to breathe. This effort plus the cloth produces the perception of "suffocation and incipient panic," i.e., the perception of drowning. The individual does not breathe water into his lungs. During those 20 to 40 seconds, water is continuously applied from a height of [12 to 24] inches. After this period, the cloth is lifted, and the individual is allowed to breathe unimpeded for three or four full breaths. The sensation of drowning is immediately relieved by the removal of the cloth. The procedure may then be repeated. The water is usually applied from a canteen cup or small watering can with a spout. . . . [T]his procedure triggers an automatic physiological sensation of drowning that the individual cannot control even though he may be aware that he is in fact not drowning. [I]t is likely that this procedure would not last more than 20 minutes in any one application.

Finally, the Agency presented OLC with a psychological profile of Abu Zubaydah and with the conclusions of officials and psychologists associated with the SERE program that the use of EITs would cause no long term mental harm. OLC relied on these representations to support its conclusion that no physical harm or prolonged mental harm would result from the use on him of the EITs, including the waterboard.<sup>26</sup>

<sup>26</sup> (TS) [REDACTED] According to the Chief, Medical Services, OMS was neither consulted nor involved in the initial analysis of the risk and benefits of EITs, nor provided with the OTS report cited in the OLC opinion. In retrospect, based on the OLC extracts of the OTS report, OMS contends that the reported sophistication of the preliminary EIT review was exaggerated, at least as it related to the waterboard, and that the power of this EIT was appreciably overstated in the report. Furthermore, OMS contends that the expertise of the SERE psychologist/interrogators on

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~~TOP SECRET~~ [REDACTED]

44. (TS [REDACTED]) OGC continued to consult with DoJ as the CTC Interrogation Program and the use of EITs expanded beyond the interrogation of Abu Zubaydah. This resulted in the production of an undated and unsigned document entitled, "Legal Principles Applicable to CIA Detention and Interrogation of Captured Al-Qa'ida Personnel."<sup>27</sup> According to OGC, this analysis was fully coordinated with and drafted in substantial part by OLC. In addition to reaffirming the previous conclusions regarding the torture statute, the analysis concludes that the federal War Crimes statute, 18 U.S.C. 2441, does not apply to Al-Qa'ida because members of that group are not entitled to prisoner of war status. The analysis adds that "the [Torture] Convention permits the use of [cruel, inhuman, or degrading treatment] in exigent circumstances, such as a national emergency or war." It also states that the interrogation of Al-Qa'ida members does not violate the Fifth and Fourteenth Amendments because those provisions do not apply extraterritorially, nor does it violate the Eighth Amendment because it only applies to persons upon whom criminal sanctions have been imposed. Finally, the analysis states that a wide range of EITs and other techniques would not constitute conduct of the type that would be prohibited by the Fifth, Eighth, or Fourteenth Amendments even were they to be applicable:

The use of the following techniques and of comparable, approved techniques does not violate any Federal statute or other law, where the CIA interrogators do not specifically intend to cause the detainee to undergo severe physical or mental pain or suffering (i.e., they act with the good faith belief that their conduct will not cause such pain or suffering): isolation, reduced caloric intake (so long as the amount is calculated to maintain the general health of the detainees), deprivation of reading material, loud music or white

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the waterboard was probably misrepresented at the time, as the SERE waterboard experience is so different from the subsequent Agency usage as to make it almost irrelevant. Consequently, according to OMS, there was no *a priori* reason to believe that applying the waterboard with the frequency and intensity with which it was used by the psychologist/interrogators was either efficacious or medically safe.

<sup>27</sup> (TS [REDACTED]) "Legal Principles Applicable to CIA Detention and Interrogation of Captured Al-Qa'ida Personnel," attached to [REDACTED] (16 June 2003).

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~~TOP SECRET~~ [REDACTED]

noise (at a decibel level calculated to avoid damage to the detainees' hearing), the attention grasp, walling, the facial hold, the facial slap (insult slap), the abdominal slap, cramped confinement, wall standing, stress positions, sleep deprivation, the use of diapers, the use of harmless insects, and the water board.

According to OGC, this analysis embodies DoJ agreement that the reasoning of the classified 1 August 2002 OLC opinion extends beyond the interrogation of Abu Zubaydah and the conditions that were specified in that opinion.

*NOTICE TO AND CONSULTATION WITH EXECUTIVE AND CONGRESSIONAL OFFICIALS*

45. (TS [REDACTED]) At the same time that OLC was reviewing the legality of EITs in the summer of 2002, the Agency was consulting with NSC policy staff and senior Administration officials. The DCI briefed appropriate senior national security and legal officials on the proposed EITs. In the fall of 2002, the Agency briefed the leadership of the Congressional Intelligence Oversight Committees on the use of both standard techniques and EITs.

46. (TS [REDACTED]) In early 2003, CIA officials, at the urging of the General Counsel, continued to inform senior Administration officials and the leadership of the Congressional Oversight Committees of the then-current status of the CTC Program. The Agency specifically wanted to ensure that these officials and the Committees continued to be aware of and approve CIA's actions. The General Counsel recalls that he spoke and met with White House Counsel and others at the NSC, as well as DoJ's Criminal Division and Office of Legal Counsel beginning in December 2002 and briefed them on the scope and breadth of the CTC's Detention and Interrogation Program.

47. (TS [REDACTED]) Representatives of the DO, in the presence of the Director of Congressional Affairs and the General Counsel, continued to brief the leadership of the Intelligence Oversight Committees on the use of EITs and detentions in February

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and March 2003. The General Counsel says that none of the participants expressed any concern about the techniques or the Program.

48. (TS [REDACTED]) On 29 July 2003, the DCI and the General Counsel provided a detailed briefing to selected NSC Principals on CIA's detention and interrogation efforts involving "high value detainees," to include the expanded use of EITs.<sup>28</sup> According to a Memorandum for the Record prepared by the General Counsel following that meeting, the Attorney General confirmed that DoJ approved of the expanded use of various EITs, including multiple applications of the waterboard.<sup>29</sup> The General Counsel said he believes everyone in attendance was aware of exactly what CIA was doing with respect to detention and interrogation, and approved of the effort. According to OGC, the senior officials were again briefed regarding the CTC Program on 16 September 2003, and the Intelligence Committee leadership was briefed again in September 2003. Again, according to OGC, none of those involved in these briefings expressed any reservations about the program.

#### ***GUIDANCE ON CAPTURE, DETENTION, AND INTERROGATION***

49. (TS [REDACTED]) Guidance and training are fundamental to the success and integrity of any endeavor as operationally, politically, and legally complex as the Agency's Detention and Interrogation Program. Soon after 9/11, the DDO issued guidance on the standards for the capture of terrorist targets. [REDACTED]

50. (TS [REDACTED]) The DCI, in January 2003 approved formal "Guidelines on Confinement Conditions for CIA Detainees" (Appendix D) and "Guidelines on Interrogations Conducted

28 [REDACTED]

29 (U//FOUO) Memorandum for the Record, [REDACTED] (5 August 2003).

~~TOP SECRET~~/ [REDACTED]

~~TOP SECRET~~ [REDACTED]

Pursuant to [REDACTED]

[REDACTED] (Appen. Jv. E), which are discussed below. Prior to the DCI Guidelines, Headquarters provided guidance via informal briefings and electronic communications, to include cables from CIA Headquarters, to the field. [REDACTED]

[REDACTED]

51. (TS [REDACTED]) In November 2002, CTC initiated training courses for individuals involved in interrogations. [REDACTED]

[REDACTED]

[REDACTED]

52. [REDACTED]

53. [REDACTED]

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[REDACTED]

51.

[REDACTED]

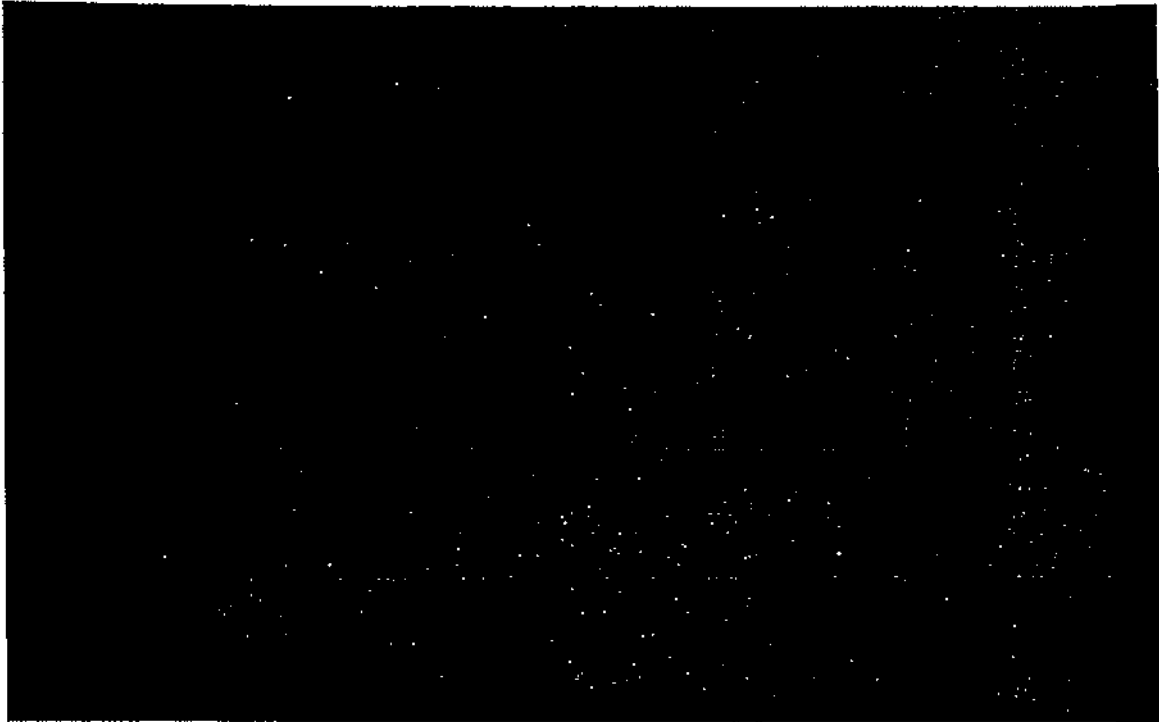
55.

[REDACTED]

56.

[REDACTED]

~~TOP SECRET~~

~~TOP SECRET~~ [REDACTED]

#### DCI Confinement Guidelines

57. (TS) [REDACTED] Before January 2003, officers assigned to manage detention facilities developed and implemented confinement condition procedures. [REDACTED]

[REDACTED] The January 2003 DCI Guidelines govern the conditions of confinement for CIA detainees held in detention facilities [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

58. [REDACTED]

[REDACTED] They must review the Guidelines and sign an acknowledgment that they have done so. [REDACTED]

59. ~~(TS)~~ [REDACTED] The DCI Guidelines specify legal "minimums" and require that "due provision must be taken to protect the health and safety of all CIA detainees." The Guidelines do not require that conditions of confinement at the detention facilities conform to U.S. prison or other standards. At a minimum, however, detention facilities are to provide basic levels of medical care:

[REDACTED]

Further, the guidelines provide that:

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

## DCI Interrogation Guidelines

60. ~~(S//NF)~~ Prior to January 2003, CTC and OGC disseminated guidance via cables, e-mail, or orally on a case-by-case basis to address requests to use specific interrogation techniques. Agency management did not require those involved in interrogations to sign an acknowledgement that they had read, understood, or agreed to comply with the guidance provided. Nor did the Agency maintain a comprehensive record of individuals who had been briefed on interrogation procedures.

61. ~~(TS)~~ [REDACTED]

The DCI Interrogation Guidelines require that all personnel directly engaged in the interrogation of persons detained have reviewed these Guidelines, received appropriate training in their implementation, and have completed the applicable acknowledgement.

62. ~~(S//NF)~~ The DCI Interrogation Guidelines define "Permissible Interrogation Techniques" and specify that "unless otherwise approved by Headquarters, CIA officers and other personnel acting on behalf of CIA may use only Permissible Interrogation Techniques. Permissible Interrogation Techniques consist of both (a) Standard Techniques and (b) Enhanced

<sup>32</sup> ~~(S//NF)~~ See [REDACTED] relevant text of DO Handbook [REDACTED]

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Techniques."<sup>33</sup> EITs require advance approval from Headquarters, as do standard techniques whenever feasible. The field must document the use of both standard techniques and EITs.

63. (~~TS~~, [REDACTED]) The DCI Interrogation Guidelines define "standard interrogation techniques" as techniques that do not incorporate significant physical or psychological pressure. These techniques include, but are not limited to, all lawful forms of questioning employed by U.S. law enforcement and military interrogation personnel. Among standard interrogation techniques are the use of isolation, sleep deprivation not to exceed 72 hours,<sup>34</sup> reduced caloric intake (so long as the amount is calculated to maintain the general health of the detainee), deprivation of reading material, use of loud music or white noise (at a decibel level calculated to avoid damage to the detainee's hearing), the use of diapers for limited periods (generally not to exceed 72 hours), [REDACTED] and moderate psychological pressure. The DCI Interrogation Guidelines do not specifically prohibit improvised actions. A CTC/Legal officer has said, however, that no one may employ any technique outside specifically identified standard techniques without Headquarters approval.

64. (~~TS~~, [REDACTED]) EITs include physical actions and are defined as "techniques that do incorporate physical or psychological pressure beyond Standard Techniques." Headquarters must approve the use of each specific EIT in advance. EITs may be employed only by trained and certified interrogators for use with a specific detainee and with appropriate medical and psychological monitoring of the process.<sup>35</sup>

<sup>33</sup> (~~TS~~) The 10 approved EITs are described in the textbox on page 15 of this Review.

<sup>34</sup> (~~TS~~, [REDACTED]) According to the General Counsel, in late December 2003, the period for sleep deprivation was reduced to 48 hours.

<sup>35</sup> (~~TS~~, [REDACTED]) Before EITs are administered, a detainee must receive a detailed psychological assessment and physical exam. [REDACTED]

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## Medical Guidelines

65. (TS [REDACTED]) OMS prepared draft guidelines for medical and psychological support to detainee interrogations. [REDACTED]

[REDACTED]

(Appendix F.)

## Training for Interrogations

66. (TS [REDACTED]) In November 2002, [REDACTED] initiated a pilot running of a two-week Interrogator Training Course designed to train, qualify, and certify individuals as Agency interrogators.<sup>37</sup> Several CTC officers,

<sup>36</sup> (U//ATDO) A 28 March 2003 Lotus Note from C/CTC/Legal advised Chief, Medical Services that the "Seventh Floor" "would need to approve the promulgation of any further formal guidelines. . . . For now, therefore, let's remain at the discussion stage. . . ."

<sup>37</sup> [REDACTED]

~~TOP SECRET~~/ [REDACTED]

~~TOP SECRET~~ [REDACTED]

including a former SERE instructor designed the curriculum, which included a week of classroom instruction followed by a week of "hands-on" training in EITs. [REDACTED]

67. (TS) [REDACTED]

[REDACTED] Once certified, an interrogator is deemed qualified to conduct an interrogation employing EITs. [REDACTED]

68. (S//NF) [REDACTED]

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[REDACTED] Students completing the Interrogation Course are required to sign an acknowledgment that they have read, understand, and will comply with the DCI's Interrogation Guidelines.

69. (TS [REDACTED]) In June 2003, CTC established a debriefing course for Agency substantive experts who are involved in questioning detainees after they have undergone interrogation and have been deemed "compliant." The debriefing course was established to train non-interrogators to collect actionable intelligence from high value detainees in CIA custody. The course is intended to familiarize non-interrogators with key aspects of the Agency interrogation Program, to include the Program's goals and legal authorities, the DCI Interrogation Guidelines, and the roles and responsibilities of all who interact with a high value detainee. [REDACTED]

*DETENTION AND INTERROGATION OPERATIONS AT* [REDACTED]

70. [REDACTED]

~~TOP SECRET~~/ [REDACTED]



~~TOP SECRET~~

[REDACTED]

[REDACTED]

71.

[REDACTED]

72.

[REDACTED]

73.

[REDACTED]

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~~TOP SECRET~~ [REDACTED]

[REDACTED]

74. (TS) [REDACTED] psychologist, interrogators [REDACTED] led each interrogation of Abu Zubaydah and Al-Nashiri where EITs were used. The psychologist, interrogators conferred with [REDACTED] team members before each interrogation session. Psychological evaluations were performed by [REDACTED] psychologists. [REDACTED]

75. [REDACTED]

[REDACTED]

76. (TS) [REDACTED]

[REDACTED] 15 November 2002. The interrogation of Al-Nashiri proceeded after [REDACTED] the necessary Headquarters authorization. [REDACTED]

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~/ [REDACTED]

psychologist/interrogators began Al-Nashiri's interrogation using EITs immediately upon his arrival. Al-Nashiri provided lead information on other terrorists during his first day of interrogation. On the twelfth day of interrogation, [REDACTED] psychologist/interrogators administered two applications of the waterboard to Al-Nashiri during two separate interrogation sessions. Enhanced interrogation of Al-Nashiri continued through 4 December 2002, [REDACTED]  
[REDACTED]

### Videotapes of Interrogations

77. (TS [REDACTED]) Headquarters had intense interest in keeping abreast of all aspects of Abu Zubaydah's interrogation [REDACTED] including compliance with the guidance provided to the site relative to the use of EITs. Apart from this, however, and before the use of EITs, the interrogation teams [REDACTED] decided to videotape the interrogation sessions. One initial purpose was to ensure a record of Abu Zubaydah's medical condition and treatment should he succumb to his wounds and questions arise about the medical care provided to him by CIA. Another purpose was to assist in the preparation of the debriefing reports, although the team advised CTC/Legal that they rarely, if ever, were used for that purpose. There are 92 videotapes, 12 of which include EIT applications. An OGC attorney reviewed the videotapes in November and December 2002 to ascertain compliance with the August 2002 DOJ opinion and compare what actually happened with what was reported to Headquarters. He reported that there was no deviation from the DOJ guidance or the written record.

78. (TS [REDACTED]) OIG reviewed the videotapes, logs, and cables [REDACTED] in May 2003. OIG identified 83 waterboard applications, most of which lasted less than 10 seconds.<sup>41</sup> [REDACTED]  
[REDACTED]

<sup>41</sup> (TS [REDACTED]) For the purpose of this Review, a waterboard application constituted each discrete instance in which water was applied for any period of time during a session.

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79. (TS [REDACTED]) OIG's review of the videotapes revealed that the waterboard technique employed at [REDACTED] was different from the technique as described in the DoJ opinion and used in the SERE training. The difference was in the manner in which the detainee's breathing was obstructed. At the SERE School and in the DoJ opinion, the subject's airflow is disrupted by the firm application of a damp cloth over the air passages; the interrogator applies a small amount of water to the cloth in a controlled manner. By contrast, the Agency interrogator [REDACTED] continuously applied large volumes of water to a cloth that covered the detainee's mouth and nose. One of the psychologists/interrogators acknowledged that the Agency's use of the technique differed from that used in SERE training and explained that the Agency's technique is different because it is "for real" and is more poignant and convincing.

[REDACTED] During this time, Headquarters issued the formal DCI Confinement Guidelines, the DCI Interrogation Guidelines, and the additional draft guidelines specifically

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addressing requirements for OMS personnel. This served to strengthen the command and control exercised over the UTV Program.

#### Background and Detainees

81. [REDACTED]

82. [REDACTED]

83. [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~/ [REDACTED]

[REDACTED]  
84. [REDACTED]  
[REDACTED]

85. [REDACTED]  
[REDACTED]

86. [REDACTED]  
[REDACTED]

87. [REDACTED]  
[REDACTED]

~~TOP SECRET~~/ [REDACTED]

~~TOP SECRET~~/ [REDACTED]

88. [REDACTED]

### Guidance Prior to DCI Guidelines

89. ~~(TS)~~ [REDACTED] the Agency was providing legal and operational briefings and cables [REDACTED] that contained Headquarters' guidance and discussed the torture statute and the DoJ legal opinion. CTC had also established a precedent of detailed cables between [REDACTED] and Headquarters regarding the interrogation and debriefing of detainees. The written guidance did not address the four standard interrogation techniques that, according to CTC/Legal, the Agency had identified as early as November 2002.<sup>43</sup> Agency personnel were authorized to employ standard interrogation techniques on a detainee without Headquarters' prior approval. The guidance did not specifically

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<sup>43</sup> ~~(S//NF)~~ The four standard interrogation techniques were: (1) sleep deprivation not to exceed 72 hours, (2) continual use of light or darkness in a cell, (3) loud music, and (4) white noise (background hum).

~~TOP SECRET~~/ [REDACTED]

~~TOP SECRET~~ [REDACTED]

address the use of props to imply a physical threat to a detainee, nor did it specifically address the issue of whether or not Agency officers could improvise with any other techniques. No formal mechanisms were in place to ensure that personnel going to the field were briefed on the existing legal and policy guidance.

### Specific Unauthorized or Undocumented Techniques

90. (TS, [REDACTED]) This Review heard allegations of the use of unauthorized techniques [REDACTED]. The most significant, the handgun and power drill incident, discussed below, is the subject of a separate OIG investigation. In addition, individuals interviewed during the Review identified other techniques that caused concern because DoJ had not specifically approved them. These included the making of threats, blowing cigar smoke, employing certain stress positions, the use of a stiff brush on a detainee, and stepping on a detainee's ankle shackles. For all of the instances, the allegations were disputed or too ambiguous to reach any authoritative determination regarding the facts. Thus, although these allegations are illustrative of the nature of the concerns held by individuals associated with the CTC Program and the need for clear guidance, they did not warrant separate investigations or administrative action.

### Handgun and Power Drill

91. (TS, [REDACTED]) [REDACTED] interrogation team members, whose purpose it was to interrogate Al-Nashiri and debrief Abu Zubaydah, initially staffed [REDACTED]. The interrogation team continued EITs on Al-Nashiri for two weeks in December 2002 [REDACTED]. They assessed him to be "compliant." Subsequently, CTC officers at Headquarters [REDACTED] sent a [REDACTED] [REDACTED] senior operations officer (the debriefer) [REDACTED] to debrief and assess Al-Nashiri.

92. (TS, [REDACTED]) The debriefer assessed Al-Nashiri as withholding information, at which point [REDACTED] reinstated [REDACTED] hooding, and handcuffing. Sometime between [REDACTED]

~~TOP SECRET~~ [REDACTED]



~~TOP SECRET~~ [REDACTED]

28 December 2002 and 1 January 2003, the debriefer used an unloaded semi-automatic handgun as a prop to frighten Al-Nashiri into disclosing information.<sup>44</sup> After discussing this plan with [REDACTED] the debriefer entered the cell where Al-Nashiri sat shackled and racked the handgun once or twice close to Al-Nashiri's head.<sup>45</sup> On what was probably the same day, the debriefer used a power drill to frighten Al-Nashiri. With [REDACTED] consent, the debriefer entered the detainee's cell and revved the drill while the detainee stood naked and hooded. The debriefer did not touch Al-Nashiri with the power drill.

93. ~~(S//NF)~~ The [REDACTED] and debriefer did not request authorization or report the use of these unauthorized techniques to Headquarters. However, in January 2003, newly arrived TDY officers [REDACTED] who had learned of these incidents reported them to Headquarters. OIG investigated and referred its findings to the Criminal Division of DoJ. On 11 September 2003, DoJ declined to prosecute and turned these matters over to CIA for disposition. These incidents are the subject of a separate OIG Report of Investigation.<sup>46</sup>

### Threats

94. ~~(TS)~~ [REDACTED] During another incident [REDACTED] the same Headquarters debriefer, according to a [REDACTED] who was present, threatened Al-Nashiri by saying that if he did not talk, "We could get your mother in here," and, "We can bring your family in here." The [REDACTED] debriefer reportedly wanted Al-Nashiri to infer, for psychological reasons, that the debriefer might be [REDACTED] intelligence officer based on his Arabic dialect, and that Al-Nashiri was in [REDACTED] custody because it was widely believed in Middle East circles that [REDACTED] interrogation technique involves

<sup>44</sup> ~~(S//NF)~~ This individual was not a trained interrogator and was not authorized to use EITs.

<sup>45</sup> ~~(S//FOUO)~~ Racking is a mechanical procedure used with firearms to chamber a bullet or simulate a bullet being chambered.

<sup>46</sup> ~~(S//NF)~~ Unauthorized Interrogation Techniques [REDACTED] 29 October 2003.

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

sexually abusing female relatives in front of the detainee. The debriefer denied threatening Al-Nashiri through his family. The debriefer also said he did not explain who he was or where he was from when talking with Al-Nashiri. The debriefer said he never said he was [REDACTED] intelligence officer but let Al-Nashiri draw his own conclusions.

95. (TS [REDACTED] An experienced Agency interrogator reported that the [REDACTED] interrogators threatened Khalid Shaykh Muhammad [REDACTED] According to this interrogator, the [REDACTED] interrogators said to Khalid Shaykh Muhammad that if anything else happens in the United States, "We're going to kill your children." According to the interrogator, one of the [REDACTED] interrogators said [REDACTED]

[REDACTED] With respect to the report provided to him of the threats [REDACTED] that report did not indicate that the law had been violated.

### Smoke

96. (TS [REDACTED] An Agency [REDACTED] interrogator admitted that, in December 2002, he and another [REDACTED] smoked cigars and blew smoke in Al-Nashiri's face during an interrogation. The interrogator claimed they did this to "cover the stench" in the room and to help keep the interrogators alert late at night. This interrogator said he would not do this again based on "perceived criticism." Another Agency interrogator admitted that he also smoked cigars during two sessions with Al-Nashiri to mask the stench in the room. He claimed he did not deliberately force smoke into Al-Nashiri's face.

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

### Stress Positions

97. (TS) [REDACTED] OIG received reports that interrogation team members employed potentially injurious stress positions on Al-Nashiri. Al-Nashiri was required to kneel on the floor and lean back. On at least one occasion, an Agency officer reportedly pushed Al-Nashiri backward while he was in this stress position. On another occasion, [REDACTED] said he had to intercede after [REDACTED] expressed concern that Al-Nashiri's arms might be dislocated from his shoulders. [REDACTED] explained that, at the time, the interrogators were attempting to put Al-Nashiri in a standing stress position. Al-Nashiri was reportedly lifted off the floor by his arms while his arms were bound behind his back with a belt.

### Stiff Brush and Shackles

98. (TS) [REDACTED] interrogator reported that he witnessed other techniques used on Al-Nashiri that the interrogator knew were not specifically approved by DoJ. These included the use of a stiff brush that was intended to induce pain on Al-Nashiri and standing on Al-Nashiri's shackles, which resulted in cuts and bruises. When questioned, an interrogator who was at [REDACTED] acknowledged that they used a stiff brush to bathe Al-Nashiri. He described the brush as the kind of brush one uses in a bath to remove stubborn dirt. A CTC manager who had heard of the incident attributed the abrasions on Al-Nashiri's ankles to an Agency officer accidentally stepping on Al-Nashiri's shackles while repositioning him into a stress position.


### Waterboard Technique

99. (TS) [REDACTED] The Review determined that the interrogators used the waterboard on Khalid Shaykh Muhammad in a manner inconsistent with the SERE application of the waterboard and the description of the waterboard in the DoJ OLC opinion, in that the technique was used on Khalid Shaykh Muhammad a large number of times. According to the General Counsel, the Attorney

~~TOP SECRET~~ [REDACTED]

General acknowledged he is fully aware of the repetitive use of the waterboard and that CIA is well within the scope of the DoJ opinion and the authority given to CIA by that opinion. The Attorney General was informed the waterboard had been used 119 times on a single individual.

100. (TS [REDACTED]) Cables indicate that Agency interrogators [REDACTED] applied the waterboard technique to Khalid Shaykh Muhammad 183 [REDACTED]



47 [REDACTED]



~~TOP SECRET~~ [REDACTED]

[REDACTED]

[REDACTED]

101. [REDACTED]

[REDACTED]

102. [REDACTED]

[REDACTED]

48 [TS] [REDACTED] The OLC opinion, dated 1 August 2011, states: "You have also orally informed us that it is likely that this procedure [waterboarding] would not last more than 20 minutes in any one application." [REDACTED]

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

[REDACTED]

103. [REDACTED]

104. [REDACTED]

105. [REDACTED]

106. [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

[REDACTED]

107. [REDACTED]

[REDACTED]

108. [REDACTED]

[REDACTED]

[REDACTED]

109. [REDACTED]

[REDACTED]

110. [REDACTED]

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~

[REDACTED]

111.

[REDACTED]

112.

[REDACTED]

50

[REDACTED]

~~TOP SECRET~~



~~TOP SECRET~~ [REDACTED]

113. [REDACTED]

[REDACTED]

114. [REDACTED]

[REDACTED]

[REDACTED]

115. [REDACTED]

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

[REDACTED]

116. [REDACTED]

[REDACTED]

117. [REDACTED]

[REDACTED]

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

118. [REDACTED]

[REDACTED]

119. [REDACTED]

[REDACTED]

120. [REDACTED]

[REDACTED]

---

53 (TS [REDACTED]) The first session of the investigation course began in November 1962. See paragraphs 64-65.

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

[REDACTED]

121. [REDACTED]

[REDACTED]

122. [REDACTED]

[REDACTED]

Interrogators are required to sign a statement certifying they have read and understand the contents of the folder. [REDACTED]

[REDACTED]

123. [REDACTED]

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

[REDACTED]

[REDACTED]

124.

[REDACTED]

125.

[REDACTED]

126.

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~

[REDACTED]

127.

[REDACTED]

128.

[REDACTED]

129.

[REDACTED]

54

[REDACTED]

55

~~TOP SECRET~~

~~TOP SECRET~~ [REDACTED]

130. [REDACTED]

131. [REDACTED]

132. [REDACTED]

133. [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

134. [REDACTED]

135. [REDACTED]

136. [REDACTED]

~~TOP SECRET~~ [REDACTED]



~~TOP SECRET~~

[REDACTED]

137.

[REDACTED]

[REDACTED]

138.

[REDACTED]

139.

[REDACTED]

~~TOP SECRET~~

~~TOP SECRET~~

[REDACTED]

140.

[REDACTED]

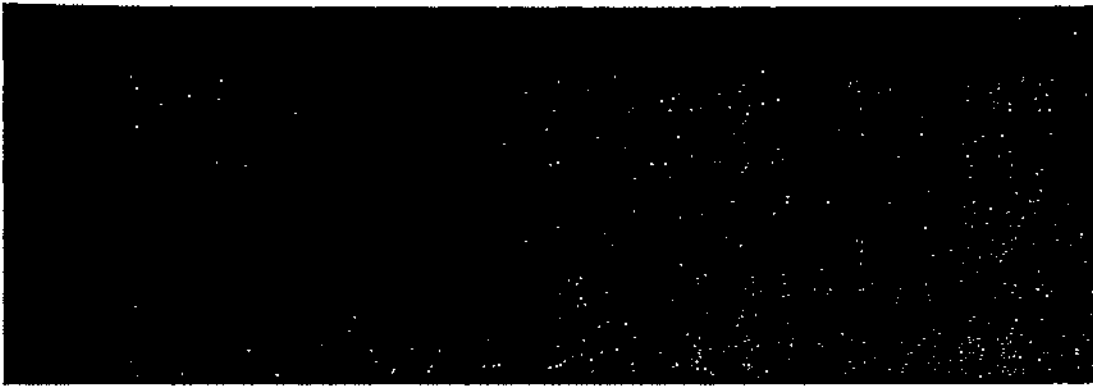
141.

[REDACTED]

[REDACTED]

~~TOP SECRET~~

~~TOP SECRET~~



142.



143.



~~TOP SECRET~~

~~TOP SECRET~~

[REDACTED]

144.

[REDACTED]

[REDACTED]

145.

[REDACTED]

[REDACTED]

~~TOP SECRET~~

~~TOP SECRET~~ [REDACTED]

[REDACTED]

146.

[REDACTED]

147.

[REDACTED]

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

148. [REDACTED]

149. [REDACTED]

150. [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

151. [REDACTED]

152. [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

[REDACTED]

153. [REDACTED]

[REDACTED]

154. [REDACTED]

[REDACTED]

155. [REDACTED]

[REDACTED]

[REDACTED]

c5

~~TOP SECRET~~ [REDACTED]



~~TOP SECRET~~

[REDACTED]

156.

[REDACTED]

157.

[REDACTED]

158.

[REDACTED]

[REDACTED]

~~TOP SECRET~~

~~TOP SECRET~~

159.

160.

~~TOP SECRET~~

~~TOP SECRET~~

[REDACTED]

161.

[REDACTED]

162.

[REDACTED]

163.

[REDACTED]

[REDACTED]

~~TOP SECRET~~

c8

~~TOP SECRET~~ [REDACTED]

### Specific Unauthorized or Undocumented Techniques

164. (TS) [REDACTED] was but one event in the early months of [REDACTED] Agency activity in [REDACTED] that involved the use of interrogation techniques that DoJ and Headquarters had not approved. Agency personnel reported a range of improvised actions that interrogators and debriefers reportedly used at that time to assist in obtaining information from detainees. The extent of these actions is illustrative of the consequences of the lack of clear guidance at that time and the Agency's insufficient attention to interrogations in [REDACTED]

165. (TS) [REDACTED] OIG opened separate investigations into two incidents: [REDACTED] and the death of a detainee at a military base in Northeast Afghanistan (discussed further in paragraph 192). These two cases presented facts that warranted criminal investigations. Some of the techniques discussed below were used with [REDACTED] and will be further addressed in connection with a Report [REDACTED]. In other cases of undocumented or unauthorized techniques, the facts are ambiguous or less serious, not warranting further investigation. Some actions discussed below were taken by employees or contractors no longer associated with the Agency. Agency management has also addressed administratively some of the actions.

### Pressure Points

166. (TS) [REDACTED] In July 2002, [REDACTED] operations officer, participated with another operations officer in a custodial interrogation of a detainee [REDACTED] reportedly used a "pressure point" technique: with both of his hands on the detainee's neck, [REDACTED] manipulated his fingers to restrict the detainee's carotid artery.

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

167. (TS [REDACTED] [REDACTED] who was facing the shackled detainee, reportedly watched his eyes to the point that the detainee would nod and start to pass out; then, the [REDACTED] shook the detainee to wake him. This process was repeated for a total of three applications on the detainee. The [REDACTED] acknowledged to OIG that he laid hands on the detainee and may have made him think he was going to lose consciousness. The [REDACTED] also noted that he has [REDACTED] years of experience debriefing and interviewing people and until recently had never been instructed how to conduct interrogations.

168. (S//NF) CTC management is now aware of this reported incident, the severity of which was disputed. The use of pressure points is not, and had not been, authorized, and CTC has advised the [REDACTED] that such actions are not authorized.

### Mock Executions

169. (TS [REDACTED] The debriefer who employed the handgun and power drill on Al-Nashir [REDACTED] advised that those actions were predicated on a technique he had participated in [REDACTED]. The debriefer stated that when he was [REDACTED] between September and October 2002, [REDACTED] offered to fire a handgun outside the interrogation room while the debriefer was interviewing a detainee who was thought to be withholding information.<sup>68</sup> [REDACTED] staged the incident, which included screaming and yelling outside the cell by other CIA officers and [REDACTED] guards. When the guards moved the detainee from the interrogation room, they passed a guard who was dressed as a hooded detainee, lying motionless on the ground, and made to appear as if he had been shot to death.

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

170. (TS) [REDACTED] The debriefer claimed he did not think he needed to report this incident because the [REDACTED] had openly discussed this plan [REDACTED] several days prior to and after the incident. When the debriefer was later [REDACTED] and believed he needed a non-traditional technique to induce the detainee to cooperate, he told [REDACTED] he wanted to wave a handgun in front of the detainee to scare him. The debriefer said he did not believe he was required to notify Headquarters of this technique, citing the earlier, unreported mock execution [REDACTED]

171. (TS) [REDACTED] A senior operations officer [REDACTED] recounted that around September 2002 [REDACTED] heard that the debriefer had staged a mock execution. [REDACTED] was not present but understood it went badly; it was transparently a ruse and no benefit was derived from it. [REDACTED] observed that there is a need to be creative as long as it is not considered torture. [REDACTED] stated that if such a proposal were made now, it would involve a great deal of consultation. It would begin with [REDACTED] management and would include CTC/Legal, [REDACTED] and the CTC [REDACTED]

172. (S//NF) The [REDACTED] admitted staging a "mock execution" in the first days that [REDACTED] was open. According to the [REDACTED] the technique was his idea but was not effective because it came across as being staged. It was based on the concept, from SERE school, of showing something that looks real, but is not. The [REDACTED] recalled that a particular CTC interrogator later told him about employing a mock execution technique. The [REDACTED] did not know when this incident occurred or if it was successful. He viewed this technique as ineffective because it was not believable.

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

173. (TS [REDACTED] Four [REDACTED] [REDACTED] who were interviewed admitted to either participating in one of the above-described incidents or hearing about them. [REDACTED]

[REDACTED] described staging a mock execution of a detainee. Reportedly, a detainee who witnessed the "body" in the aftermath of the ruse "sang like a bird."

174. (TS [REDACTED] revealed that approximately four days before his interview with OIG, the [REDACTED] stated he had conducted a mock execution [REDACTED] in October or November 2002. Reportedly, the firearm was discharged outside of the building, and it was done because the detainee reportedly possessed critical threat information. [REDACTED] stated that he told the [REDACTED] not to do it again. He stated that he has not heard of a similar act occurring [REDACTED] since then.

#### Use of Smoke

175. (TS [REDACTED] A CIA officer [REDACTED] revealed that cigarette smoke was once used as an interrogation technique in October 2002. Reportedly, at the request of [REDACTED] an interrogator, the officer, who does not smoke, blew the smoke from a thin cigarette/cigar in the detainee's face for about five minutes. The detainee started talking so the smoke ceased. [REDACTED] heard that a different officer had used smoke as an interrogation technique. OIG questioned numerous personnel who had worked [REDACTED] about the use of smoke as a technique. None reported any knowledge of the use of smoke as an interrogation technique.

176. (TS [REDACTED] [REDACTED] admitted that he has personally used smoke inhalation techniques on detainees to make them ill to the point where they would start to "purge." After this, in a weakened state,

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

these detainees would then provide [REDACTED] with information.<sup>70</sup> [REDACTED] denied ever physically abusing detainees or knowing anyone who has.

### Use of Cold

177. [REDACTED]

178. (TS) [REDACTED] In late July to early August 2002, a detainee was being interrogated [REDACTED]. Prior to proceeding with any of the proposed methods, [REDACTED] officer responsible for the detainee [REDACTED] requesting Headquarters authority to employ a prescribed interrogation plan over a two-week period. The plan included the following:

Physical Comfort Level Deprivation: With use of a window air conditioner and a judicious provision/deprivation of warm clothing/blankets, believe we can increase [the detainee's] physical discomfort level to the point where we may lower his mental/trained resistance abilities.

CTC/Legal responded and advised, "[C]autious must be used when employing the air conditioning/blanket deprivation so that [the detainee's] discomfort does not lead to a serious illness or worse."

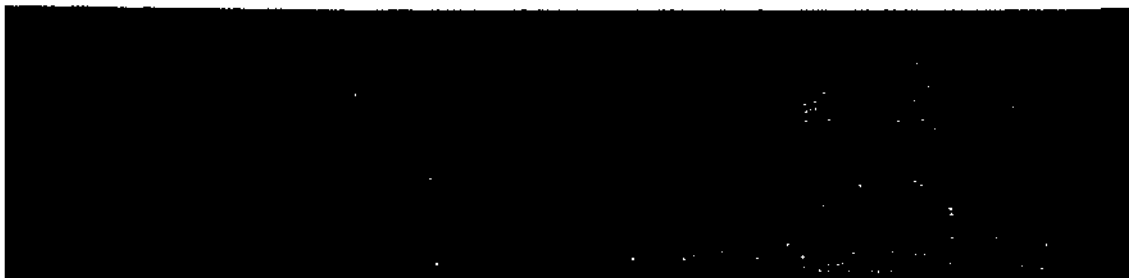
179. [REDACTED]

<sup>70</sup> (TS) This was substantiated in part by the CIA officer who participated in this act with the [REDACTED]

~~TOP SECRET~~ [REDACTED]



~~TOP SECRET~~



180.



181



182.



~~TOP SECRET~~

~~TOP SECRET~~ [REDACTED]

183. (TS/ [REDACTED] Many of the officers interviewed about the use of cold showers as a technique cited that the water heater was inoperable and there was no other recourse except for cold showers. However, [REDACTED] explained that if a detainee was cooperative, he would be given a warm shower. He stated that when a detainee was uncooperative, the interrogators accomplished two goals by combining the hygienic reason for a shower with the unpleasantness of a cold shower.

184. (TS/ [REDACTED] In December 2002, [REDACTED] cable [REDACTED] reported that a detainee was left in a cold room, shackled and naked, until he demonstrated cooperation.

185. (TS/ [REDACTED] When asked in February 2003, if cold was used as an interrogation technique, the [REDACTED] responded, "not per se." He explained that physical and environmental discomfort was used to encourage the detainees to improve their environment. [REDACTED] observed that cold is hard to define. He asked rhetorically, "How cold is cold? How cold is life threatening?" He stated that cold water was still employed [REDACTED] however, showers were administered in a heated room. He stated there was no specific guidance on it from Headquarters, and [REDACTED] was left to its own discretion in the use of cold. [REDACTED] added there is a cable from [REDACTED] documenting the use of "manipulation of the environment."

186. (TS/ [REDACTED] Although the DCI Guidelines do not mention cold as a technique, the September 2003 draft OMS Guidelines on Medical and Psychological Support to Detainee Interrogations specifically identify an "uncomfortably cool environment" as a standard interrogation measure. (Appendix F.) The OMS Guidelines provide detailed instructions on safe temperature ranges, including the safe temperature range when a detainee is wet or unclothed.

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

## Water Dousing

187. (TS/ [REDACTED] According to [REDACTED] and others who have worked [REDACTED] "water dousing" has been used [REDACTED] since early 2003 when [REDACTED] officer introduced this technique to the facility. Dousing involves laying a detainee down on a plastic sheet and pouring water over him for 10 to 15 minutes. Another officer explained that the room was maintained at 70 degrees or more; the guards used water that was at room temperature while the interrogator questioned the detainee.

188. (TS/ [REDACTED] A review [REDACTED] from April and May 2003 revealed that [REDACTED] sought permission from CTC [REDACTED] to employ specific techniques for a number of detainees. Included in the list of requested techniques was water dousing.<sup>72</sup> Subsequent cables reported the use and duration of the techniques by detainee per interrogation session.<sup>73</sup> One certified interrogator, noting that water dousing appeared to be a most effective technique, requested CTC to confirm guidelines on water dousing. A return cable directed that the detainee must be placed on a towel or sheet, may not be placed naked on the bare cement floor, and the air temperature must exceed 65 degrees if the detainee will not be dried immediately.

189. (TS/ [REDACTED] The DCI Guidelines do not mention water dousing as a technique. The 4 September 2003 draft OMS Guidelines, however, identify "water dousing" as one of 12 standard measures that OMS listed, in ascending degree of intensity, as the 11th standard measure. OMS did not further address "water dousing" in its guidelines.

<sup>73</sup> (TS/ [REDACTED] reported water dousing as a technique used, but in a later paragraph used the term "cold water bath."

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]**Hard Takedown**

190. [REDACTED]

191. (TS/ [REDACTED] According to [REDACTED] the hard takedown was used often in interrogations at [REDACTED] as "part of the atmospherics." For a time, it was the standard procedure for moving a detainee to the sleep deprivation cell. It was done for shock and psychological impact and signaled the transition to another phase of the interrogation. The act of putting a detainee into a diaper can cause abrasions if the detainee struggles because the floor of the facility is concrete. The [REDACTED] stated he did not discuss the hard takedown with [REDACTED] managers, but he thought they understood what techniques were being used at [REDACTED]. [REDACTED] stated that the hard takedown had not been used recently [REDACTED]. After taking the interrogation class, he understood that if [REDACTED]

[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

he was going to do a hard takedown, he must report it to Headquarters. Although the DCI and OMS Guidelines address physical techniques and treat them as requiring advance Headquarters approval, they do not otherwise specifically address the "hard takedown."

192. ~~(TS/)~~ [REDACTED] stated that he was generally familiar with the technique of hard takedowns. He asserted that they are authorized and believed they had been used one or more times at [REDACTED] in order to intimidate a detainee. [REDACTED] stated that he would not necessarily know if they have been used and did not consider it a serious enough handling technique to require Headquarters approval. Asked about the possibility that a detainee may have been dragged on the ground during the course of a hard takedown, [REDACTED] responded that he was unaware of that and did not understand the point of dragging someone along the corridor in [REDACTED]

#### Abuse [REDACTED] at Other Locations Outside of the CTC Program

193. ~~(TS/)~~ [REDACTED] Although not within the scope of the CTC Program, two other incidents [REDACTED] were reported in 2003. [REDACTED]

[REDACTED] As noted above, one resulted in the death of a detainee at Asadabad Base<sup>76</sup> [REDACTED]

194. ~~(S//NF)~~ In June 2003, the U.S. military sought an Afghan citizen who had been implicated in rocket attacks on a joint U.S. Army and CIA position in Asadabad located in Northeast Afghanistan. On 18 June 2003, this individual appeared at Asadabad Base at the urging of the local Governor. The individual was held in a detention facility guarded by U.S. soldiers from the Base. During

<sup>76</sup> ~~(S)~~ For more than a year, CIA referred to Asadabad Base as [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

the four days the individual was detained, an Agency independent contractor, who was a paramilitary officer, is alleged to have severely beaten the detainee with a large metal flashlight and kicked him during interrogation sessions. The detainee died in custody on 21 June; his body was turned over to a local cleric and returned to his family on the following date without an autopsy being performed. Neither the contractor nor his Agency staff supervisor had been trained or authorized to conduct interrogations. The Agency did not renew the independent contractor's contract, which was up for renewal soon after the incident. OIG is investigating this incident in concert with DoJ.<sup>77</sup>

195. (S//NF) In July 2003, [REDACTED] officer assigned to [REDACTED] assaulted a teacher at a religious school [REDACTED]. This assault occurred during the course of an interview during a joint operation [REDACTED].

[REDACTED] The objective was to determine if anyone at the school had information about the detonation of a remote-controlled improvised explosive device that had killed eight border guards several days earlier.

196. (S//NF) A teacher being interviewed [REDACTED] reportedly smiled and laughed inappropriately, whereupon [REDACTED] used the butt stock of his rifle to strike or "buttstroke" the teacher at least twice in his torso, followed by several knee kicks to his torso. This incident was witnessed by 200 students. The teacher was reportedly not seriously injured. In response to his actions, Agency management returned the [REDACTED] to Headquarters. He was counseled and given a domestic assignment.

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~

197.

198.

~~TOP SECRET~~

~~TOP SECRET~~ [REDACTED]

[REDACTED]

199.

[REDACTED]

200.

[REDACTED]

201.

[REDACTED]

~~TOP SECRET~~ [REDACTED]



~~TOP SECRET~~ [REDACTED]

[REDACTED]

202. [REDACTED]

[REDACTED]

203. [REDACTED]

[REDACTED]

*ANALYTICAL SUPPORT TO INTERROGATIONS*

204. (TS [REDACTED]) Directorate of Intelligence analysts assigned to CTC provide analytical support to interrogation teams in the field. Analysts are responsible for developing requirements for the questioning of detainees as well as conducting debriefings in some cases. [REDACTED]

[REDACTED] Analysts, however, do not participate in the application of interrogation techniques.

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

205. ~~(TS)~~ [REDACTED] According to a number of those interviewed for this Review, the Agency's intelligence on Al-Qa'ida was limited prior to the initiation of the CTC Interrogation Program. The Agency lacked adequate linguists or subject matter experts and had very little hard knowledge of what particular Al-Qa'ida leaders—who later became detainees—knew. This lack of knowledge led analysts to speculate about what a detainee "should know," vice information the analyst could objectively demonstrate the detainee did know. [REDACTED]  
[REDACTED]

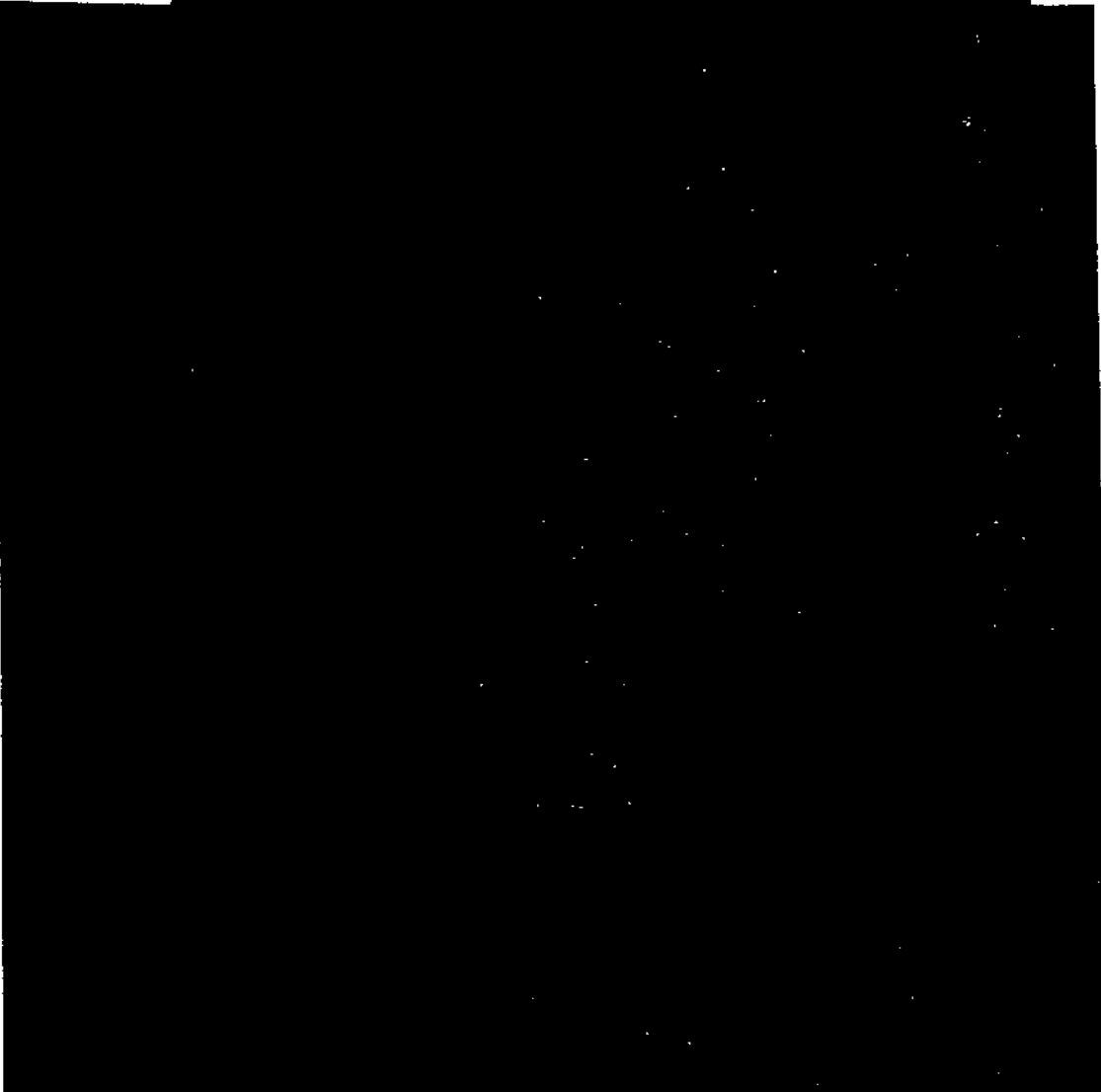
206. ~~(TS)~~ [REDACTED]  
[REDACTED] When a detainee did not respond to a question posed to him, the assumption at Headquarters was that the detainee was holding back and knew more; consequently, Headquarters recommended resumption of EITs.

207. [REDACTED]  
[REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

208. [REDACTED]



209. (TS) [REDACTED]

[REDACTED] is  
evidenced in the final waterboard session of Abu Zubaydah.  
According to a senior CIC officer, the interrogation team [REDACTED]  
[REDACTED] considered Abu Zubaydah to be compliant and wanted to  
terminate EITs. [REDACTED] believed Abu Zubaydah continued to  
withhold information. [REDACTED]

[REDACTED] at the time it

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

generated substantial pressure from Headquarters to continue use of the EITs. According to this senior officer, the decision to resume use of the waterboard on Abu Zubaydah was made by senior officers of the DO [REDACTED]

[REDACTED] to assess Abu Zubaydah's compliance and witnessed the final waterboard session, after which, they reported back to Headquarters that the EITs were no longer needed on Abu Zubaydah.

210. [REDACTED]

#### *EFFECTIVENESS*

211. (TS, [REDACTED]) The detention of terrorists has prevented them from engaging in further terrorist activity, and their interrogation has provided intelligence that has enabled the identification and apprehension of other terrorists, warned of terrorists plots planned for the United States and around the world, and supported articles frequently used in the finished intelligence publications for senior policymakers and war fighters. In this regard, there is no doubt that the Program has been effective. Measuring the effectiveness of EITs, however, is a more subjective process and not without some concern.

212. (TS, [REDACTED]) When the Agency began capturing terrorists, management judged the success of the effort to be getting them off the streets, [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

[REDACTED]

With the capture of terrorists who had access to much more significant, actionable information, the measure of success of the Program increasingly became the intelligence obtained from the detainees.

213. (TS [REDACTED]) Quantitatively, the DO has significantly increased the number of counterterrorism intelligence reports with the inclusion of information from detainees in its custody. Between 9/11 and the end of April 2003, the Agency produced over 3,000 intelligence reports from detainees. Most of the reports came from intelligence provided by the high value detainees at [REDACTED]

214. (TS [REDACTED]) CTC frequently uses the information from one detainee, as well as other sources, to vet the information of another detainee. Although lower-level detainees provide less information than the high value detainees, information from these detainees has, on many occasions, supplied the information needed to probe the high value detainees further.

[REDACTED] the triangulation of intelligence provides a fuller knowledge of Al-Qa'ida activities than would be possible from a single detainee. For example, Mustafa Ahmad Adam al-Hawsawi, the Al-Qa'ida financier who was captured with Khalid Shaykh Muhammad, provided the Agency's first intelligence pertaining to [REDACTED]—another participant in the 9/11 terrorist plot. [REDACTED] Hawsawi's information to obtain additional details about [REDACTED] role from Khalid Shaykh Muhammad [REDACTED]

215. (TS [REDACTED]) Detainees have provided information on Al-Qa'ida and other terrorist groups. Information of note includes: the modus operandi of Al-Qa'ida, [REDACTED] terrorists who are capable of mounting attacks in the United States, [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

[REDACTED]

216. (TS [REDACTED]) Detainee information has assisted in the identification of terrorists. For example, information from Abu Zubaydah helped lead to the identification of Jose Padilla and Binyam Muhammed—operatives who had plans to detonate a uranium-topped dirty bomb in either Washington, D.C., or New York City. Riduan "Hambali" Isomuddin provided information that led to the arrest of previously unknown members of an Al-Qa'ida cell in Karachi. They were designated as pilots for an aircraft attack inside the United States. Many other detainees, including lower-level detainees such as Zubayr and Majid Khan, have provided leads to other terrorists, but probably the most prolific has been Khalid Shaykh Muhammad. He provided information that helped lead to the arrests of terrorists including Sayfullah Paracha and his son Uzair Paracha, businessmen whom Khalid Shaykh Muhammad planned to use to smuggle explosives into the United States; Saleh Almari, a sleeper operative in New York; and Majid Khan, an operative who could enter the United States easily and was tasked to research attacks [REDACTED] Khalid Shaykh Muhammad's information also led to the investigation and prosecution of Iyman Faris, the truck driver arrested in early 2003 in Ohio. [REDACTED]

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

[REDACTED]

217. (TS) [REDACTED] Detainees, both planners and operatives, have also made the Agency aware of several plots planned for the United States and around the world. The plots identify plans to [REDACTED] attack the U.S. Consulate in Karachi, Pakistan; hijack aircraft to fly into Heathrow Airport [REDACTED] loosen track spikes in an attempt to derail a train in the United States; [REDACTED] blow up several U.S. gas stations to create panic and havoc; hijack and fly an airplane into the tallest building in California in a west coast version of the World Trade Center attack; cut the lines of suspension bridges in New York in an effort to make them collapse; [REDACTED]

[REDACTED] This Review did not uncover any evidence that these plots were imminent. Agency senior managers believe that lives have been saved as a result of the capture and interrogation of terrorists who were planning attacks, in particular Khalid Shaykh Muhammad, Abu Zubaydah, Hambali, and Al-Nashiri.

218. (TS) [REDACTED] judge the reporting from detainees as one of the most important sources for finished intelligence. [REDACTED] viewed analysts' knowledge of the terrorist target as having much more depth as a result of information from detainees and estimated that detainee reporting is used in all counterterrorism articles produced for the most senior policymakers. [REDACTED]

[REDACTED] In an interview, the DCI

~~TOP SECRET~~ [REDACTED]

~~TOP SECRET~~ [REDACTED]

said he believes the use of EITs has proven to be extremely valuable in obtaining enormous amounts of critical threat information from detainees who had otherwise believed they were safe from any harm in the hands of Americans.

219. [REDACTED]

220. (TS [REDACTED]) Inasmuch as EITs have been used only since August 2002, and they have not all been used with every high value detainee, there is limited data on which to assess their individual effectiveness. This Review identified concerns about the use of the waterboard, specifically whether the risks of its use were justified by the results, whether it has been unnecessarily used in some instances, and whether the fact that it is being applied in a manner different from its use in SERE training brings into question the continued applicability of the DoJ opinion to its use. Although the waterboard is the most intrusive of the EITs, the fact that precautions have been taken to provide on-site medical oversight in the use of all EITs is evidence that their use poses risks.

221. (TS [REDACTED]) Determining the effectiveness of each EIT is important in facilitating Agency management's decision as to which techniques should be used and for how long. Measuring the overall effectiveness of EITs is challenging for a number of reasons including: (1) the Agency cannot determine with any certainty the totality of the intelligence the detainee actually possesses; (2) each detainee has different fears of and tolerance for EITs; (3) the application of the same EITs by different interrogators may have

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different results; and [REDACTED]  
[REDACTED]

222. (TS, [REDACTED]) The waterboard has been used on three detainees: Abu Zubaydah, Al-Nashiri, and Khalid Shaykh Muhammad. [REDACTED]  
[REDACTED]

[REDACTED] with the belief that each of the three detainees possessed perishable information about imminent threats against the United States.

223. (TS, [REDACTED]) Prior to the use of EITs, Abu Zubaydah provided information for [REDACTED] intelligence reports. Interrogators applied the waterboard to Abu Zubaydah at least 83 times during August 2002. During the period between the end of the use of the waterboard and 30 April 2003, he provided information for approximately [REDACTED] additional reports. It is not possible to say definitively that the waterboard is the reason for Abu Zubaydah's increased production, or if another factor, such as the length of detention, was the catalyst. Since the use of the waterboard, however, Abu Zubaydah has appeared to be cooperative, [REDACTED]  
[REDACTED]

224. (TS, [REDACTED]) With respect to Al-Nashiri, [REDACTED] reported two waterboard sessions in November 2002, after which the psychologist/interrogators determined that Al-Nashiri was compliant. However, after being moved [REDACTED]  
[REDACTED]

[REDACTED] Al-Nashiri was thought to be withholding information. Al-Nashiri subsequently received additional EITs, [REDACTED] but not the waterboard. The Agency then determined Al-Nashiri to be "compliant." Because of the litany of

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techniques used by different interrogators over a relatively short period of time, it is difficult to identify exactly why Al-Nashiri became more willing to provide information. However, following the use of EITs, he provided information about his most current operational planning and [REDACTED] as opposed to the historical information he provided before the use of EITs.

225. (TS [REDACTED]) On the other hand, Khalid Shaykh Muhammad, an accomplished resistor, provided only a few intelligence reports prior to the use of the waterboard, and analysis of that information revealed that much of it was outdated, inaccurate, or incomplete. As a means of less active resistance, at the beginning of their interrogation, detainees routinely provide information that they know is already known. Khalid Shaykh Muhammad received 183 applications of the waterboard in March 2003 [REDACTED]

[REDACTED]

*POLICY CONSIDERATIONS AND CONCERNS REGARDING THE DETENTION  
AND INTERROGATION PROGRAM*

226. (TS [REDACTED]) The EITs used by the Agency under the CTC Program are inconsistent with the public policy positions that the United States has taken regarding human rights. This divergence has been a cause of concern to some Agency personnel involved with the Program.

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## Policy Considerations

227. ~~(U//FOUO)~~ Throughout its history, the United States has been an international proponent of human rights and has voiced opposition to torture and mistreatment of prisoners by foreign countries. This position is based upon fundamental principles that are deeply embedded in the American legal structure and jurisprudence. The Fifth and Fourteenth Amendments to the U.S. Constitution, for example, require due process of law, while the Eighth Amendment bars "cruel and unusual punishments."

228. ~~(U//FOUO)~~ The President advised the Senate when submitting the Torture Convention for ratification that the United States would construe the requirement of Article 16 of the Convention to "undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman, or degrading treatment or punishment which do not amount to torture" as "roughly equivalent to" and "coextensive with the Constitutional guarantees against cruel, unusual, and inhumane treatment."<sup>81</sup> To this end, the United States submitted a reservation to the Torture Convention stating that the United States considers itself bound by Article 16 "only insofar as the term 'cruel, inhuman or degrading treatment or punishment' means the cruel, unusual, and inhumane treatment or punishment prohibited by the 5th, 8th and/or 14th Amendments to the Constitution of the United States." Although the Torture Convention expressly provides that no exceptional circumstances whatsoever, including war or any other public emergency, and no order from a superior officer, justifies torture, no similar provision was included regarding acts of "cruel, inhuman or degrading treatment or punishment."

<sup>81</sup> ~~(U//FOUO)~~ See Message from the President of the United States Transmitting the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Sen. Treaty Doc. 100-20, 100<sup>th</sup> Cong., 2d Sess., at 15, May 23, 1988; Senate Committee on Foreign Relations, Executive Report 101-30, August 30, 1990, at 25, 29, quoting summary and analysis submitted by President Ronald Reagan, as revised by President George H.W. Bush.

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229. ~~(U//FOUO)~~ Annual U.S. State Department Country Reports on Human Rights Practices have repeatedly condemned harsh interrogation techniques utilized by foreign governments. For example, the 2002 Report, issued in March 2003, stated:

[The United States] have been given greater opportunity to make good on our commitment to uphold standards of human dignity and liberty . . . . [N]o country is exempt from scrutiny, and all countries benefit from constant striving to identify their weaknesses and improve their performance . . . . [T]he Reports serve as a gauge for our international human rights efforts, pointing to areas of progress and drawing our attention to new and continuing challenges.

In a world marching toward democracy and respect for human rights, the United States is a leader, a partner and a contributor. We have taken this responsibility with a deep and abiding belief that human rights are universal. They are not grounded exclusively in American or western values. But their protection worldwide serves a core U.S. national interest.

The State Department Report identified objectionable practices in a variety of countries including, for example; patterns of abuse of prisoners in Saudi Arabia by such means as "suspension from bars by handcuffs, and threats against family members, . . . [being] forced constantly to lie on hard floors [and] deprived of sleep . . . ." Other reports have criticized hooding and stripping prisoners naked.

230. ~~(U//FOUO)~~ In June 2003, President Bush issued a statement in observance of "United Nations International Day in Support of Victims of Torture." The statement said in part:

The United States declares its strong solidarity with torture victims across the world. Torture anywhere is an affront to human dignity everywhere. We are committed to building a world where human rights are respected and protected by the rule of law.

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Freedom from torture is an inalienable human right . . . . Yet torture continues to be practiced around the world by rogue regimes whose cruel methods match their determination to crush the human spirit . . . .

Notorious human rights abusers . . . have sought to shield their abuses from the eyes of the world by staging elaborate deceptions and denying access to international human rights monitors . . . .

The United States is committed to the worldwide elimination of torture and we are leading this fight by example. I call on all governments to join with the United States and the community of law-abiding nations in prohibiting, investigating, and prosecuting all acts of torture and in undertaking to prevent other cruel and unusual punishment . . . .

### Concerns Over Participation in the CTC Program

231. ~~(S//NF)~~ During the course of this Review, a number of Agency officers expressed unsolicited concern about the possibility of recrimination or legal action resulting from their participation in the CTC Program. A number of officers expressed concern that a human rights group might pursue them for activities [REDACTED]. Additionally, they feared that the Agency would not stand behind them if this occurred.

232. ~~(S//NF)~~ One officer expressed concern that one day, Agency officers will wind up on some "wanted list" to appear before the World Court for war crimes stemming from activities [REDACTED]. Another said, "Ten years from now we're going to be sorry we're doing this . . . [but] it has to be done." He expressed concern that the CTC Program will be exposed in the news media and cited particular concern about the possibility of being named in a leak.

233. [REDACTED]

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[REDACTED]

234.

[REDACTED]

235.

[REDACTED]

*ENDGAME*

236.

[REDACTED]

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[REDACTED]

237. (TS [REDACTED]) The number of detainees in CIA custody is relatively small by comparison with those in U.S. military custody. Nevertheless, the Agency, like the military, has an interest in the disposition of detainees and particular interest in those who, if not kept in isolation, would likely divulge information about the circumstances of their detention.

238. [REDACTED]

[REDACTED]

239. [REDACTED]

[REDACTED]

82 [REDACTED]

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240. [REDACTED]

241. [REDACTED]

242. [REDACTED]

243. [REDACTED]

244. [REDACTED]

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245. (TS) [REDACTED] does not appear to have been given consideration to prosecution as a viable possibility at least in the near term. At this date, however, no decision has been made to proceed with this option.

246. [REDACTED]

247. [REDACTED]

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(U//FOUO) [REDACTED]

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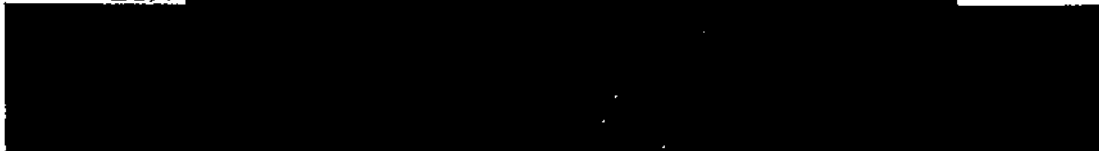
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248. [REDACTED]



249. [REDACTED]



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## CONCLUSIONS

250. (TS, [REDACTED]) The Agency's detention and interrogation of terrorists has provided intelligence that has enabled the identification and apprehension of other terrorists and warned of terrorist plots planned for the United States and around the world. The CTC Detention and Interrogation Program has resulted in the issuance of thousands of individual intelligence reports and analytic products supporting the counterterrorism efforts of U.S. policymakers and military commanders. The effectiveness of particular interrogation techniques in eliciting information that might not otherwise have been obtained cannot be so easily measured, however.

251. (TS, [REDACTED]) After 11 September 2001, numerous Agency components and individuals invested immense time and effort to implement the CTC Program quickly, effectively, and within the law. The work of the Directorate of Operations, Counterterrorist Center (CTC), Office of General Counsel (OGC), Office of Medical Services (OMS), Office of Technical Service (OTS) [REDACTED] [REDACTED] has been especially notable. In effect, they began with almost no foundation, as the Agency had discontinued virtually all involvement in interrogations after encountering difficult issues with earlier interrogation programs in Central America and the Near East. Inevitably, there also have been some problems with current activities.

252. (S//NF) OGC worked closely with DoJ to determine the legality of the measures that came to be known as enhanced interrogation techniques (EITs). OGC also consulted with White House and National Security Council officials regarding the proposed techniques. Those efforts and the resulting DoJ legal opinion of 1 August 2002 are well documented. That legal opinion was based, in substantial part, on OTS analysis and the experience and expertise of non-Agency personnel and academics concerning whether long-term psychological effects would result from use of the proposed techniques.

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253. ~~(S//NF)~~ The DoJ legal opinion upon which the Agency relies is based upon technical definitions of "severe" treatment and the "intent" of the interrogators, and consists of finely detailed analysis to buttress the conclusion that Agency officers properly carrying out EITs would not violate the Torture Convention's prohibition of torture, nor would they be subject to criminal prosecution under the U.S. torture statute. The opinion does not address the separate question of whether the application of standard or enhanced techniques by Agency officers is consistent with the undertaking, accepted conditionally by the United States regarding Article 16 of the Torture Convention, to prevent "cruel, inhuman or degrading treatment or punishment."

254. ~~(TS)~~ [REDACTED] Periodic efforts by the Agency to elicit reaffirmation of Administration policy and DoJ legal backing for the Agency's use of EITs—as they have actually been employed—have been well advised and successful. However, in this process, Agency officials have neither sought nor been provided a written statement of policy or a formal signed update of the DoJ legal opinion, including such important determinations as the meaning and applicability of Article 16 of the Torture Convention. In July 2003, the DCI and the General Counsel briefed senior Administration officials on the Agency's expanded use of EITs. At that time, the Attorney General affirmed that the Agency's conduct remained well within the scope of the 1 August 2002 DoJ legal opinion.

255. ~~(TS)~~ [REDACTED] A number of Agency officers of various grade levels who are involved with detention and interrogation activities are concerned that they may at some future date be vulnerable to legal action in the United States or abroad and that the U.S. Government will not stand behind them. Although the current detention and interrogation Program has been subject to DoJ legal review and Administration political approval, it diverges sharply from previous Agency policy and practice, rules that govern interrogations by U.S. military and law enforcement officers, statements of U.S. policy by the Department of State, and public

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statements by very senior U.S. officials, including the President, as well as the policies expressed by Members of Congress, other Western governments, international organizations, and human rights groups. In addition, some Agency officers are aware of interrogation activities that were outside or beyond the scope of the written DoJ opinion. Officers are concerned that future public revelation of the CTC Program is inevitable and will seriously damage Agency officers' personal reputations, as well as the reputation and effectiveness of the Agency itself.

256. (TS, [REDACTED]) The Agency has generally provided good guidance and support to its officers who have been detaining and interrogating high value terrorists using EITs pursuant to [REDACTED]

[REDACTED] In particular, CTC did a commendable job in directing the interrogations of high value detainees at [REDACTED]. At these foreign locations, Agency personnel—with one notable exception described in this Review—followed guidance and procedures and documented their activities well.

257. (TS, [REDACTED]) By distinction, the Agency—especially in the early months of the Program—failed to provide adequate staffing, guidance, and support to those involved with the detention and interrogation of detainees in [REDACTED]

258. (TS, [REDACTED]) Unauthorized, improvised, inhumane, and undocumented detention and interrogation techniques were used [REDACTED] referred to the Department of Justice (DoJ) for potential prosecution. [REDACTED] incident will be the

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subject of a separate Report of Investigation by the Office of Inspector General. [REDACTED]

unauthorized techniques were used in the interrogation of an individual who died at Asadabad Base while under interrogation by an Agency contractor in June 2003. Agency officers did not normally conduct interrogations at that location [REDACTED] the Agency officers involved lacked timely and adequate guidance, training, experience, supervision, or authorization, and did not exercise sound judgment.

259. (TS [REDACTED]) The Agency failed to issue in a timely manner comprehensive written guidelines for detention and interrogation activities. Although ad hoc guidance was provided to many officers through cables and briefings in the early months of detention and interrogation activities, the DCI Confinement and Interrogation Guidelines were not issued until January 2003, several months after initiation of interrogation activity and after many of the unauthorized activities had taken place. [REDACTED]

260. (TS [REDACTED]) Such written guidance as does exist to address detentions and interrogations undertaken by Agency officers [REDACTED] is inadequate. The Directorate of Operations Handbook contains a single paragraph that is intended to guide officers [REDACTED] Neither this dated guidance nor general Agency guidelines on routine intelligence collection is adequate to instruct and protect Agency officers involved in contemporary interrogation activities. [REDACTED]

261. (TS [REDACTED]) During the interrogations of two detainees, the waterboard was used in a manner inconsistent with the written DoJ legal opinion of 1 August 2002. DoJ had stipulated that

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its advice was based upon certain facts that the Agency had submitted to DoJ, observing, for example, that "... you (the Agency) have also orally informed us that although some of these techniques may be used with more than once [sic], that repetition will not be substantial because the techniques generally lose their effectiveness after several repetitions." One key Al-Qa'ida terrorist was subjected to the waterboard at least 183 times [REDACTED] and was denied sleep for a period of 180 hours. In this and another instance, the technique of application and volume of water used differed from the DoJ opinion.

262. (TS, [REDACTED]) OMS provided comprehensive medical attention to detainees [REDACTED] where EITs were employed with high value detainees, [REDACTED]

[REDACTED] OMS did not issue formal medical guidelines until April 2003. Per the advice of CTC/Legal, the OMS Guidelines were then issued as "draft" and remain so even after being re-issued in September 2003.

263: [REDACTED]

264. (TS, [REDACTED]) Agency officers report that reliance on analytical assessments that were unsupported by credible intelligence may have resulted in the application of EITs without justification. Some participants in the Program, particularly field interrogators, judge that CTC assessments to the effect that detainees are withholding information are not always supported by an objective

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evaluation of available information and the evaluation of the interrogators but are too heavily based, instead, on presumptions of what the individual might or should know.

265. [REDACTED]

266. (TS [REDACTED]) The Agency faces potentially serious long-term political and legal challenges as a result of the CTC Detention and Interrogation Program, particularly its use of EITs and the inability of the U.S. Government to decide what it will ultimately do with terrorists detained by the Agency.

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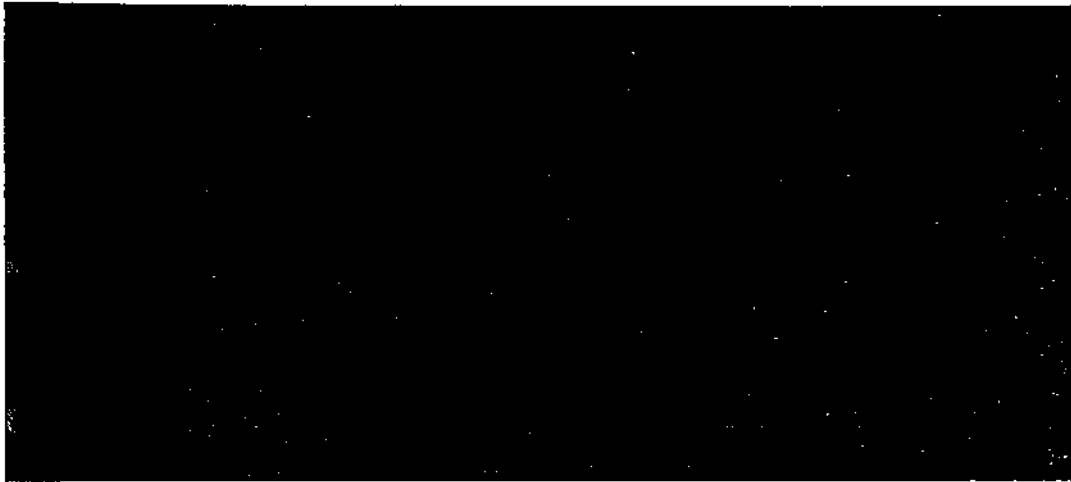
## RECOMMENDATIONS

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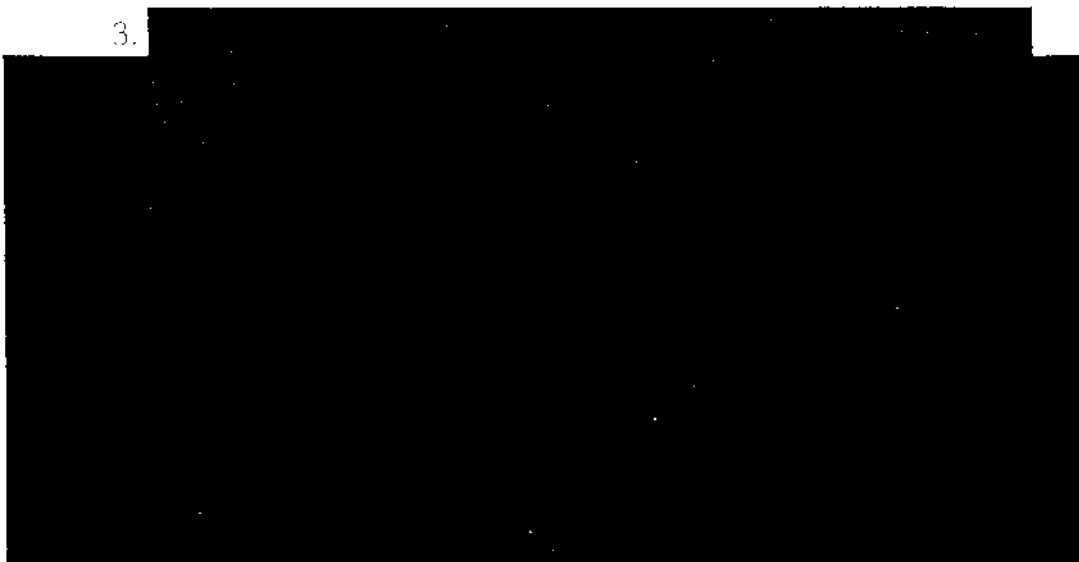


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[REDACTED]

8. [REDACTED]

[REDACTED]

9. [REDACTED]

[REDACTED]

10. [REDACTED]

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## Appendix A

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## PROCEDURES AND RESOURCES

1. (TS [REDACTED]) A team, led by the Deputy Inspector General, and comprising the Assistant Inspector General for Investigations, the Counsel to the Inspector General, a senior Investigations Staff Manager, three Investigators, two Inspectors, an Auditor, a Research Assistant, and a Secretary participated in this Review.
2. (TS [REDACTED]) OIG tasked relevant components for all information regarding the treatment and interrogation of all individuals detained by or on behalf of CIA after 9/11. Agency components provided OIG with over 38,000 pages of documents. OIG conducted over 100 interviews with individuals who possessed potentially relevant information. We interviewed senior Agency management officials, including the DCI, the Deputy Director of Central Intelligence, the Executive Director, the General Counsel, and the Deputy Director for Operations. As new information developed, OIG re-interviewed several individuals.
3. (TS [REDACTED]) OIG personnel made site visits to the [REDACTED] interrogation facilities. OIG personnel also visited [REDACTED] to review 92 videotapes of interrogations of Abu Zubaydah [REDACTED]

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## Appendix B

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## CHRONOLOGY: COUNTERTERRORISM DETENTION AND INTERROGATION ACTIVITIES

Date	Event in Washington		
2001 Sept			
	CIA/ODC begins research on interrogations issues.		
2001 Nov			
2002 Mar			Abu Zubaydah captured in Pakistan on 27 March 02
2002 Apr			
2002 Jul	CIA briefs selected policy makers on EITs in summer 2002. CIA seeks legal opinion from DoJ for use of EITs on Abu Zubaydah.		
2002 Aug	DoJ concludes that use of 10 EITs, as described by CIA, would not violate U.S. law.		Agency initiates use of EITs on Abu Zubaydah.
2002 Sept			
2002 Fall	CIA briefs leadership of Congressional oversight committees.		
2002 Nov	CTC implements training program for officers assigned to the Interrogation Program.		Al-Nashiri captured EITs employed on Al-Nashiri.
2002 Dec			Unauthorized interrogation techniques used on Al-Nashiri in late December or early January.
2003 Jan	ODC initiates review of interrogation activities. DCI issues Confinement and Interrogation Guidelines.		
2003 Feb-Mar	CIA briefs leadership of Congressional oversight committees.		
2003 Mar		Khalid Shaykh Muhammad captured	EITs employed on Khalid Shaykh Muhammad.
2003 Apr	ODC disseminates draft guidelines for treatment of detainees.		
2003 Jun	ODC Capture Guidelines require that subject pose a continuing serious threat.	Abd al Wali dies after being interrogated by CIA	
2003 Jul	Attorney General reaffirms legality.	Teacher assaulted	
2003 Sep	ODC updates guidelines for detainee treatment.		

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## Appendix C

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U.S. Department of Justice

Office of Legal Counsel

Office of the Assistant Attorney General

Washington, D.C. 20530

August 1, 2002

Memorandum for John Rizzo  
Acting General Counsel of the Central Intelligence Agency

*Interrogation of al Qaeda Operative*

You have asked for this Office's views on whether certain proposed conduct would violate the prohibition against torture found at Section 2340A of title 18 of the United States Code. You have asked for this advice in the course of conducting interrogations of Abu Zubaydah. As we understand it, Zubaydah is one of the highest ranking members of the al Qaeda terrorist organization, with which the United States is currently engaged in an international armed conflict following the attacks on the World Trade Center and the Pentagon on September 11, 2001. This letter memorializes our previous oral advice, given on July 24, 2002 and July 26, 2002, that the proposed conduct would not violate this prohibition.

## I.

Our advice is based upon the following facts, which you have provided to us. We also understand that you do not have any facts in your possession contrary to the facts outlined here, and this opinion is limited to these facts. If these facts were to change, this advice would not necessarily apply. Zubaydah is currently being held by the United States. The interrogation team is certain that he has additional information that he refuses to divulge. Specifically, he is withholding information regarding terrorist networks in the United States or in Saudi Arabia and information regarding plans to conduct attacks within the United States or against our interests overseas. Zubaydah has become accustomed to a certain level of treatment and displays no signs of willingness to disclose further information. Moreover, your intelligence indicates that there is currently a level of "chatter" equal to that which preceded the September 11 attacks. In light of the information you believe Zubaydah has and the high level of threat you believe now exists, you wish to move the interrogations into what you have described as an "increased pressure phase."

As part of this increased pressure phase, Zubaydah will have contact only with a new interrogation specialist, whom he has not met previously, and the Survival, Evasion, Resistance, Escape ("SERE") training psychologist who has been involved with the interrogations since they began. This phase will likely last no more than several days but could last up to thirty days. In this phase, you would like to employ ten techniques that you believe will dislocate his

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expectations regarding the treatment he believes he will receive and encourage him to disclose the crucial information mentioned above. These ten techniques are: (1) attention grasp, (2) walling, (3) facial hold, (4) facial slap (insult slap), (5) cramped confinement, (6) wall standing, (7) stress positions, (8) sleep deprivation, (9) insects placed in a confinement box, and (10) the waterboard. You have informed us that the use of these techniques would be on an as-needed basis and that not all of these techniques will necessarily be used. The interrogation team would use these techniques in some combination to convince Zubaydah that the only way he can influence his surrounding environment is through cooperation. You have, however, informed us that you expect these techniques to be used in some sort of escalating fashion, culminating with the waterboard, though not necessarily ending with this technique. Moreover, you have also orally informed us that although some of these techniques may be used with more than once, that repetition will not be substantial because the techniques generally lose their effectiveness after several repetitions. You have also informed us that Zubaydah sustained a wound during his capture, which is being treated.

Based on the facts you have given us, we understand each of these techniques to be as follows. The attention grasp consists of grasping the individual with both hands, one hand on each side of the collar opening, in a controlled and quick motion. In the same motion as the grasp, the individual is drawn toward the interrogator.

For walling, a flexible false wall will be constructed. The individual is placed with his heels touching the wall. The interrogator pulls the individual forward and then quickly and firmly pushes the individual into the wall. It is the individual's shoulder blades that hit the wall. During this motion, the head and neck are supported with a rolled hood or towel that provides a c-collar effect to help prevent whiplash. To further reduce the probability of injury, the individual is allowed to rebound from the flexible wall. You have orally informed us that the false wall is in part constructed to create a loud sound when the individual hits it, which will further shock or surprise the individual. In part, the idea is to create a sound that will make the impact seem far worse than it is and that will be far worse than any injury that might result from the action.

The facial hold is used to hold the head immobile. One open palm is placed on either side of the individual's face. The fingertips are kept well away from the individual's eyes.

With the facial slap or insult slap, the interrogator slaps the individual's face with fingers slightly spread. The hand makes contact with the area directly between the tip of the individual's chin and the bottom of the corresponding earlobe. The interrogator invades the individual's personal space. The goal of the facial slap is not to inflict physical pain that is severe or lasting. Instead, the purpose of the facial slap is to induce shock, surprise, and/or humiliation.

Cramped confinement involves the placement of the individual in a confined space, the dimensions of which restrict the individual's movement. The confined space is usually dark.

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The duration of confinement varies based upon the size of the container. For the larger confined space, the individual can stand up or sit down; the smaller space is large enough for the subject to sit down. Confinement in the larger space can last up to eighteen hours; for the smaller space, confinement lasts for no more than two hours.

Wall standing is used to induce muscle fatigue. The individual stands about four to five feet from a wall, with his feet spread approximately to shoulder width. His arms are stretched out in front of him, with his fingers resting on the wall. His fingers support all of his body weight. The individual is not permitted to move or reposition his hands or feet.

A variety of stress positions may be used. You have informed us that these positions are not designed to produce the pain associated with contortions or twisting of the body. Rather, somewhat like walling, they are designed to produce the physical discomfort associated with muscle fatigue. Two particular stress positions are likely to be used on Zubaydah: (1) sitting on the floor with legs extended straight out in front of him with his arms raised above his head; and (2) kneeling on the floor while leaning back at a 45 degree angle. You have also orally informed us that through observing Zubaydah in captivity, you have noted that he appears to be quite flexible despite his wound.

Sleep deprivation may be used. You have indicated that your purpose in using this technique is to reduce the individual's ability to think on his feet and, through the discomfort associated with lack of sleep, to motivate him to cooperate. The effect of such sleep deprivation will generally remit after one or two nights of uninterrupted sleep. You have informed us that your research has revealed that, in rare instances, some individuals who are already predisposed to psychological problems may experience abnormal reactions to sleep deprivation. Even in those cases, however, reactions abate after the individual is permitted to sleep. Moreover, personnel with medical training are available to and will intervene in the unlikely event of an abnormal reaction. You have orally informed us that you would not deprive Zubaydah of sleep for more than eleven days at a time and that you have previously kept him awake for 72 hours, from which no mental or physical harm resulted.

You would like to place Zubaydah in a cramped confinement box with an insect. You have informed us that he appears to have a fear of insects. In particular, you would like to tell Zubaydah that you intend to place a stinging insect into the box with him. You would, however, place a harmless insect in the box. You have orally informed us that you would in fact place a harmless insect such as a caterpillar in the box with him.

Finally, you would like to use a technique called the "waterboard." In this procedure, the individual is bound securely to an inclined bench, which is approximately four feet by seven feet. The individual's feet are generally elevated. A cloth is placed over the forehead and eyes. Water

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is then applied to the cloth in a controlled manner. As this is done, the cloth is lowered until it covers both the nose and mouth. Once the cloth is saturated and completely covers the mouth and nose, air flow is slightly restricted for 20 to 40 seconds due to the presence of the cloth. This causes an increase in carbon dioxide level in the individual's blood. This increase in the carbon dioxide level stimulates increased effort to breathe. This effort plus the cloth produces the perception of "suffocation and incipient panic," i.e., the perception of drowning. The individual does not breathe any water into his lungs. During those 20 to 40 seconds, water is continuously applied from a height of twelve to twenty-four inches. After this period, the cloth is lifted, and the individual is allowed to breathe unimpeded for three or four full breaths. The sensation of drowning is immediately relieved by the removal of the cloth. The procedure may then be repeated. The water is usually applied from a canteen cup or small watering can with a spout. You have orally informed us that this procedure triggers an automatic physiological sensation of drowning that the individual cannot control even though he may be aware that he is in fact not drowning. You have also orally informed us that it is likely that this procedure would not last more than 20 minutes in any one application.

We also understand that a medical expert with SERE experience will be present throughout this phase and that the procedures will be stopped if deemed medically necessary to prevent severe mental or physical harm to Zubaydah. As mentioned above, Zubaydah suffered an injury during his capture. You have informed us that steps will be taken to ensure that this injury is not in any way exacerbated by the use of these methods and that adequate medical attention will be given to ensure that it will heal properly.

## II.

In this part, we review the context within which these procedures will be applied. You have informed us that you have taken various steps to ascertain what effect, if any, these techniques would have on Zubaydah's mental health. These same techniques, with the exception of the insect in the cramped confined space, have been used and continue to be used on some members of our military personnel during their SERE training. Because of the use of these procedures in training our own military personnel to resist interrogations, you have consulted with various individuals who have extensive experience in the use of these techniques. You have done so in order to ensure that no prolonged mental harm would result from the use of these proposed procedures.

Through your consultation with various individuals responsible for such training, you have learned that these techniques have been used as elements of a course of conduct without any reported incident of prolonged mental harm. [REDACTED] of the SERE school, [REDACTED] has reported that, during the seven-year period that he spent in those positions, there were two requests from Congress for information concerning alleged injuries resulting from the training. One of these inquiries was prompted by the temporary physical injury a trainee sustained as result of being placed in a

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confinement box. The other inquiry involved claims that the SERE training caused two individuals to engage in criminal behavior, namely, felony shoplifting and downloading child pornography onto a military computer. According to this official, these claims were found to be baseless. Moreover, he has indicated that during the three and a half years he spent as [REDACTED] of the SERE program, he trained 10,000 students. Of those students, only two dropped out of the training following the use of these techniques. Although on rare occasions some students temporarily postponed the remainder of their training and received psychological counseling, those students were able to finish the program without any indication of subsequent mental health effects.

You have informed us that you have consulted with [REDACTED] who has ten years of experience with SERE training [REDACTED]

[REDACTED] He stated that, during those ten years, insofar as he is aware, none of the individuals who completed the program suffered any adverse mental health effects. He informed you that there was one person who did not complete the training. That person experienced an adverse mental health reaction that lasted only two hours. After those two hours, the individual's symptoms spontaneously dissipated without requiring treatment or counseling and no other symptoms were ever reported by this individual. According to the information you have provided to us, this assessment of the use of these procedures includes the use of the waterboard.

Additionally, you received a memorandum from the [REDACTED] which you supplied to us. [REDACTED] has experience with the use of all of these procedures in a course of conduct, with the exception of the insect in the confinement box and the waterboard. This memorandum confirms that the use of these procedures has not resulted in any reported instances of prolonged mental harm, and very few instances of immediate and temporary adverse psychological responses to the training. [REDACTED] reported that a small minority of students have had temporary adverse psychological reactions during training. Of the 26,829 students trained from 1992 through 2001 in the Air Force SERE training, 4.3 percent of those students had contact with psychology services. Of those 4.3 percent, only 3.2 percent were pulled from the program for psychological reasons. Thus, out of the students trained overall, only 0.14 percent were pulled from the program for psychological reasons. Furthermore, although [REDACTED] indicated that surveys of students having completed this training are not done, he expressed confidence that the training did not cause any long-term psychological impact. He based his conclusion on the debriefing of students that is done after the training. More importantly, he based this assessment on the fact that although training is required to be extremely stressful in order to be effective, very few complaints have been made regarding the training. During his tenure, in which 10,000 students were trained, no congressional complaints have been made. While there was one Inspector General complaint, it was not due to psychological concerns. Moreover, he was aware of only one letter inquiring about the long-term impact of these techniques from an individual trained

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over twenty years ago. He found that it was impossible to attribute this individual's symptoms to his training. [REDACTED] concluded that if there are any long-term psychological effects of the United States Air Force training using the procedures outlined above they "are certainly minimal."

With respect to the waterboard, you have also orally informed us that the Navy continues to use it in training. You have informed us that your on-site psychologists, who have extensive experience with the use of the waterboard in Navy training, have not encountered any significant long-term mental health consequences from its use. Your on-site psychologists have also indicated that JPRA has likewise not reported any significant long-term mental health consequences from the use of the waterboard. You have informed us that other services ceased use of the waterboard because it was so successful as an interrogation technique, but not because of any concerns over any harm, physical or mental, caused by it. It was also reported to be almost 100 percent effective in producing cooperation among the trainees. [REDACTED] also indicated that he had observed the use of the waterboard in Navy training some ten to twelve times. Each time it resulted in cooperation but it did not result in any physical harm to the student.

You have also reviewed the relevant literature and found no empirical data on the effect of these techniques, with the exception of sleep deprivation. With respect to sleep deprivation, you have informed us that is not uncommon for someone to be deprived of sleep for 72 hours and still perform excellently on visual-spatial motor tasks and short-term memory tests. Although some individuals may experience hallucinations, according to the literature you surveyed, those who experience such psychotic symptoms have almost always had such episodes prior to the sleep deprivation. You have indicated the studies of lengthy sleep deprivation showed no psychosis, loosening of thoughts, flattening of emotions, delusions, or paranoid ideas. In one case, even after eleven days of deprivation, no psychosis or permanent brain damage occurred. In fact the individual reported feeling almost back to normal after one night's sleep. Further, based on the experiences with its use in military training (where it is induced for up to 48 hours), you found that rarely, if ever, will the individual suffer harm after the sleep deprivation is discontinued. Instead, the effects remit after a few good nights of sleep.

You have taken the additional step of consulting with U.S. interrogations experts, and other individuals with oversight over the SERE training process. None of these individuals was aware of any prolonged psychological effect caused by the use of any of the above techniques either separately or as a course of conduct. Moreover, you consulted with outside psychologists who reported that they were unaware of any cases where long-term problems have occurred as a result of these techniques.

Moreover, in consulting with a number of mental health experts, you have learned that the effect of any of these procedures will be dependant on the individual's personal history, cultural history and psychological tendencies. To that end, you have informed us that you have

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completed a psychological assessment of Zubaydah. This assessment is based on interviews with Zubaydah, observations of him, and information collected from other sources such as intelligence and press reports. Our understanding of Zubaydah's psychological profile, which we set forth below, is based on that assessment.

According to this assessment, Zubaydah, though only 31, rose quickly from very low level mujahedin to third or fourth man in al Qaeda. He has served as Usama Bin Laden's senior lieutenant. In that capacity, he has managed a network of training camps. He has been instrumental in the training of operatives for al Qaeda, the Egyptian Islamic Jihad, and other terrorist elements inside Pakistan and Afghanistan. He acted as the Deputy Camp Commander for al Qaeda training camp in Afghanistan, personally approving entry and graduation of all trainees during 1999-2000. From 1996 until 1999, he approved all individuals going in and out of Afghanistan to the training camps. Further, no one went in and out of Peshawar, Pakistan without his knowledge and approval. He also acted as al Qaeda's coordinator of external contacts and foreign communications. Additionally, he has acted as al Qaeda's counter-intelligence officer and has been trusted to find spies within the organization.

Zubaydah has been involved in every major terrorist operation carried out by al Qaeda. He was a planner for the Millennium plot to attack U.S. and Israeli targets during the Millennium celebrations in Jordan. Two of the central figures in this plot who were arrested have identified Zubaydah as the supporter of their cell and the plot. He also served as a planner for the Paris Embassy plot in 2001. Moreover, he was one of the planners of the September 11 attacks. Prior to his capture, he was engaged in planning future terrorist attacks against U.S. interests.

Your psychological assessment indicates that it is believed Zubaydah wrote al Qaeda's manual on resistance techniques. You also believe that his experiences in al Qaeda make him well-acquainted with and well-versed in such techniques. As part of his role in al Qaeda, Zubaydah visited individuals in prison and helped them upon their release. Through this contact and activities with other al Qaeda mujahedin, you believe that he knows many stories of capture, interrogation, and resistance to such interrogation. Additionally, he has spoken with Ayman al-Zawahiri, and you believe it is likely that the two discussed Zawahiri's experiences as a prisoner of the Russians and the Egyptians.

Zubaydah stated during interviews that he thinks of any activity outside of jihad as "silly." He has indicated that his heart and mind are devoted to serving Allah and Islam through jihad and he has stated that he has no doubts or regrets about committing himself to jihad. Zubaydah believes that the global victory of Islam is inevitable. You have informed us that he continues to express his unabated desire to kill Americans and Jews.

Your psychological assessment describes his personality as follows. He is "a highly self-directed individual who prizes his independence." He has "narcissistic features," which are evidenced in the attention he pays to his personal appearance and his "obvious 'efforts' to

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demonstrate that he is really a rather "humble and regular guy." He is "somewhat compulsive" in how he organizes his environment and business. He is confident, self-assured, and possesses an air of authority. While he admits to at times wrestling with how to determine who is an "innocent," he has acknowledged celebrating the destruction of the World Trade Center. He is intelligent and intellectually curious. He displays "excellent self-discipline." The assessment describes him as a perfectionist, persistent, private, and highly capable in his social interactions. He is very guarded about opening up to others and your assessment repeatedly emphasizes that he tends not to trust others easily. He is also "quick to recognize and assess the moods and motivations of others." Furthermore, he is proud of his ability to lie and deceive others successfully. Through his deception he has, among other things, prevented the location of al Qaeda safehouses and even acquired a United Nations refugee identification card.

According to your reports, Zubaydah does not have any pre-existing mental conditions or problems that would make him likely to suffer prolonged mental harm from your proposed interrogation methods. Through reading his diaries and interviewing him, you have found no history of "mood disturbance or other psychiatric pathology[.]" "thought disorder[.]" "enduring mood or mental health problems." He is in fact "remarkably resilient and confident that he can overcome adversity." When he encounters stress or low mood, this appears to last only for a short time. He deals with stress by assessing its source, evaluating the coping resources available to him, and then taking action. Your assessment notes that he is "generally self-sufficient and relies on his understanding and application of religious and psychological principles, intelligence and discipline to avoid and overcome problems." Moreover, you have found that he has a "reliable and durable support system" in his faith, "the blessings of religious leaders, and camaraderie of like-minded mujahedin brothers." During detention, Zubaydah has managed his mood, remaining at most points "circumspect, calm, controlled, and deliberate." He has maintained this demeanor during aggressive interrogations and reductions in sleep. You describe that in an initial confrontational incident, Zubaydah showed signs of sympathetic nervous system arousal, which you think was possibly fear. Although this incident led him to disclose intelligence information, he was able to quickly regain his composure, his air of confidence, and his "strong resolve" not to reveal any information.

Overall, you summarize his primary strengths as the following: ability to focus, goal-directed discipline, intelligence, emotional resilience, street savvy, ability to organize and manage people, keen observation skills, fluid adaptability (can anticipate and adapt under duress and with minimal resources), capacity to assess and exploit the needs of others, and ability to adjust goals to emerging opportunities.

You anticipate that he will draw upon his vast knowledge of interrogation techniques to cope with the interrogation. Your assessment indicates that Zubaydah may be willing to die to protect the most important information that he holds. Nonetheless, you are of the view that his belief that Islam will ultimately dominate the world and that this victory is inevitable may provide the chance that Zubaydah will give information and rationalize it solely as a temporary

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setback. Additionally, you believe he may be willing to disclose some information, particularly information he deems to not be critical, but which may ultimately be useful to us when pieced together with other intelligence information you have gained.

### III.

Section 2340A makes it a criminal offense for any person "outside of the United States [to] commit[] or attempt[] to commit torture." Section 2340(1) defines torture as:

an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody of physical control.

18 U.S.C. § 2340(1). As we outlined in our opinion on standards of conduct under Section 2340A, a violation of 2340A requires a showing that: (1) the torture occurred outside the United States; (2) the defendant acted under the color of law; (3) the victim was within the defendant's custody or control; (4) the defendant specifically intended to inflict severe pain or suffering; and (5) that the act inflicted severe pain or suffering. See Memorandum for John Rizzo, Acting General Counsel for the Central Intelligence Agency, from Jay S. Bybee, Assistant Attorney General, Office of Legal Counsel, *Re: Standards of Conduct for Interrogation under 18 U.S.C. §§ 2340-2340A* at 3 (August 1, 2002) ("Section 2340A Memorandum"). You have asked us to assume that Zubaydah is being held outside the United States, Zubaydah is within U.S. custody, and the interrogators are acting under the color of law. At issue is whether the last two elements would be met by the use of the proposed procedures, namely, whether those using these procedures would have the requisite mental state and whether these procedures would inflict severe pain or suffering within the meaning of the statute.

Severe Pain or Suffering. In order for pain or suffering to rise to the level of torture, the statute requires that it be severe. As we have previously explained, this reaches only extreme acts. See *id.* at 13. Nonetheless, drawing upon cases under the Torture Victim Protection Act (TVPA), which has a definition of torture that is similar to Section 2340's definition, we found that a single event of sufficiently intense pain may fall within this prohibition. See *id.* at 26. As a result, we have analyzed each of these techniques separately. In further drawing upon those cases, we also have found that courts tend to take a totality-of-the-circumstances approach and consider an entire course of conduct to determine whether torture has occurred. See *id.* at 27. Therefore, in addition to considering each technique separately, we consider them together as a course of conduct.

Section 2340 defines torture as the infliction of severe physical or mental pain or suffering. We will consider physical pain and mental pain separately. See 18 U.S.C. § 2340(1). With respect to *physical* pain, we previously concluded that "severe pain" within the meaning of

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Section 2340 is pain that is difficult for the individual to endure and is of an intensity akin to the pain accompanying serious physical injury. See Section 2340A Memorandum at 6. Drawing upon the TVPA precedent, we have noted that examples of acts inflicting severe pain that typify torture are, among other things, severe beatings with weapons such as clubs, and the burning of prisoners. See *id.* at 24. We conclude below that none of the proposed techniques inflicts such pain.

The facial hold and the attention grasp involve no physical pain. In the absence of such pain it is obvious that they cannot be said to inflict severe physical pain or suffering. The stress positions and wall standing both may result in muscle fatigue. Each involves the sustained holding of a position. In wall standing, it will be holding a position in which all of the individual's body weight is placed on his finger tips. The stress positions will likely include sitting on the floor with legs extended straight out in front and arms raised above the head, and kneeling on the floor and leaning back at a 45 degree angle. Any pain associated with muscle fatigue is not of the intensity sufficient to amount to "severe physical pain or suffering" under the statute, nor, despite its discomfort, can it be said to be difficult to endure. Moreover, you have orally informed us that no stress position will be used that could interfere with the healing of Zubaydah's wound. Therefore, we conclude that these techniques involve discomfort that falls far below the threshold of severe physical pain.

Similarly, although the confinement boxes (both small and large) are physically uncomfortable because their size restricts movement, they are not so small as to require the individual to contort his body to sit (small box) or stand (large box). You have also orally informed us that despite his wound, Zubaydah remains quite flexible, which would substantially reduce any pain associated with being placed in the box. We have no information from the medical experts you have consulted that the limited duration for which the individual is kept in the boxes causes any substantial physical pain. As a result, we do not think the use of these boxes can be said to cause pain that is of the intensity associated with serious physical injury.

The use of one of these boxes with the introduction of an insect does not alter this assessment. As we understand it, no actually harmful insect will be placed in the box. Thus, though the introduction of an insect may produce trepidation in Zubaydah (which we discuss below), it certainly does not cause physical pain.

As for sleep deprivation, it is clear that depriving someone of sleep does not involve severe physical pain within the meaning of the statute. While sleep deprivation may involve some physical discomfort, such as the fatigue or the discomfort experienced in the difficulty of keeping one's eyes open, these effects remit after the individual is permitted to sleep. Based on the facts you have provided us, we are not aware of any evidence that sleep deprivation results in severe physical pain or suffering. As a result, its use does not violate Section 2340A.

Even those techniques that involve physical contact between the interrogator and the

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individual do not result in severe pain. The facial slap and walling contain precautions to ensure that no pain even approaching this level results. The slap is delivered with fingers slightly spread, which you have explained to us is designed to be less painful than a closed-hand slap. The slap is also delivered to the fleshy part of the face, further reducing any risk of physical damage or serious pain. The facial slap does not produce pain that is difficult to endure. Likewise, walling involves quickly pulling the person forward and then thrusting him against a flexible false wall. You have informed us that the sound of hitting the wall will actually be far worse than any possible injury to the individual. The use of the rolled towel around the neck also reduces any risk of injury. While it may hurt to be pushed against the wall, any pain experienced is not of the intensity associated with serious physical injury.

As we understand it, when the waterboard is used, the subject's body responds as if the subject were drowning—even though the subject may be well aware that he is in fact not drowning. You have informed us that this procedure does not inflict actual physical harm. Thus, although the subject may experience the fear or panic associated with the feeling of drowning, the waterboard does not inflict physical pain. As we explained in the Section 2340A Memorandum, "pain and suffering" as used in Section 2340 is best understood as a single concept, not distinct concepts of "pain" as distinguished from "suffering." See Section 2340A Memorandum at 6 n.3. The waterboard, which inflicts no pain or actual harm whatsoever, does not, in our view inflict "severe pain or suffering." Even if one were to parse the statute more finely to attempt to treat "suffering" as a distinct concept, the waterboard could not be said to inflict severe suffering. The waterboard is simply a controlled acute episode, lacking the connotation of a protracted period of time generally given to suffering.

Finally, as we discussed above, you have informed us that in determining which procedures to use and how you will use them, you have selected techniques that will not harm Zubaydah's wound. You have also indicated that numerous steps will be taken to ensure that none of these procedures in any way interferes with the proper healing of Zubaydah's wound. You have also indicated that, should it appear at any time that Zubaydah is experiencing severe pain or suffering, the medical personnel on hand will stop the use of any technique.

Even when all of these methods are considered combined in an overall course of conduct, they still would not inflict severe physical pain or suffering. As discussed above, a number of these acts result in no physical pain, others produce only physical discomfort. You have indicated that these acts will not be used with substantial repetition, so that there is no possibility that severe physical pain could arise from such repetition. Accordingly, we conclude that these acts neither separately nor as part of a course of conduct would inflict severe physical pain or suffering within the meaning of the statute.

We next consider whether the use of these techniques would inflict severe *mental* pain or suffering within the meaning of Section 2340. Section 2340 defines severe mental pain or suffering as "the prolonged mental harm caused by or resulting from" one of several predicate

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acts. 18 U.S.C. § 2340(2). Those predicate acts are: (1) the intentional infliction or threatened infliction of severe physical pain or suffering; (2) the administration or application, or threatened administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality; (3) the threat of imminent death; or (4) the threat that any of the preceding acts will be done to another person. See 18 U.S.C. § 2340(2)(A)-(D). As we have explained, this list of predicate acts is exclusive. See Section 2340A Memorandum at 8. No other acts can support a charge under Section 2340A based on the infliction of severe mental pain or suffering. See *id.* Thus, if the methods that you have described do not either in and of themselves constitute one of these acts or as a course of conduct fulfill the predicate act requirement, the prohibition has not been violated. See *id.* Before addressing these techniques, we note that it is plain that none of these procedures involves a threat to any third party, the use of any kind of drugs, or for the reasons described above, the infliction of severe physical pain. Thus, the question is whether any of these acts, separately or as a course of conduct, constitutes a threat of severe physical pain or suffering, a procedure designed to disrupt profoundly the senses, or a threat of imminent death. As we previously explained, whether an action constitutes a threat must be assessed from the standpoint of a reasonable person in the subject's position. See *id.* at 9.

No argument can be made that the attention grasp or the facial hold constitute threats of imminent death or are procedures designed to disrupt profoundly the senses or personality. In general the grasp and the facial hold will startle the subject, produce fear, or even insult him. As you have informed us, the use of these techniques is not accompanied by a specific verbal threat of severe physical pain or suffering. To the extent that these techniques could be considered a threat of severe physical pain or suffering, such a threat would have to be inferred from the acts themselves. Because these actions themselves involve no pain, neither could be interpreted by a reasonable person in Zubaydah's position to constitute a threat of severe pain or suffering. Accordingly, these two techniques are not predicate acts within the meaning of Section 2340.

The facial slap likewise falls outside the set of predicate acts. It plainly is not a threat of imminent death, under Section 2340(2)(C), or a procedure designed to disrupt profoundly the senses or personality, under Section 2340(2)(B). Though it may hurt, as discussed above, the effect is one of smarting or stinging and surprise or humiliation, but not severe pain. Nor does it alone constitute a threat of severe pain or suffering, under Section 2340(2)(A). Like the facial hold and the attention grasp, the use of this slap is not accompanied by a specific verbal threat of further escalating violence. Additionally, you have informed us that in one use this technique will typically involve at most two slaps. Certainly, the use of this slap may dislodge any expectation that Zubaydah had that he would not be touched in a physically aggressive manner. Nonetheless, this alteration in his expectations could hardly be construed by a reasonable person in his situation to be tantamount to a threat of severe physical pain or suffering. At most, this technique suggests that the circumstances of his confinement and interrogation have changed. Therefore, the facial slap is not within the statute's exclusive list of predicate acts.

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Walling plainly is not a procedure calculated to disrupt profoundly the senses or personality. While walling involves what might be characterized as rough handling, it does not involve the threat of imminent death or, as discussed above, the infliction of severe physical pain. Moreover, once again we understand that use of this technique will not be accompanied by any specific verbal threat that violence will ensue absent cooperation. Thus, like the facial slap, walling can only constitute a threat of severe physical pain if a reasonable person would infer such a threat from the use of the technique itself. Walling does not in and of itself inflict severe pain or suffering. Like the facial slap, walling may alter the subject's expectation as to the treatment he believes he will receive. Nonetheless, the character of the action falls so far short of inflicting severe pain or suffering within the meaning of the statute that even if he inferred that greater aggressiveness was to follow, the type of actions that could be reasonably be anticipated would still fall below anything sufficient to inflict severe physical pain or suffering under the statute. Thus, we conclude that this technique falls outside the proscribed predicate acts.

Like walling, stress positions and wall-standing are not procedures calculated to disrupt profoundly the senses, nor are they threats of imminent death. These procedures, as discussed above, involve the use of muscle fatigue to encourage cooperation and do not themselves constitute the infliction of severe physical pain or suffering. Moreover, there is no aspect of violence to either technique that remotely suggests future severe pain or suffering from which such a threat of future harm could be inferred. They simply involve forcing the subject to remain in uncomfortable positions. While these acts may indicate to the subject that he may be placed in these positions again if he does not disclose information, the use of these techniques would not suggest to a reasonable person in the subject's position that he is being threatened with severe pain or suffering. Accordingly, we conclude that these two procedures do not constitute any of the predicate acts set forth in Section 2340(2).

As with the other techniques discussed so far, cramped confinement is not a threat of imminent death. It may be argued that, focusing in part on the fact that the boxes will be without light, placement in these boxes would constitute a procedure designed to disrupt profoundly the senses. As we explained in our recent opinion, however, to "disrupt profoundly the senses" a technique must produce an extreme effect in the subject. See Section 2340A Memorandum at 10-12. We have previously concluded that this requires that the procedure cause substantial interference with the individual's cognitive abilities or fundamentally alter his personality. See *id.* at 11. Moreover, the statute requires that such procedures must be calculated to produce this effect. See *id.* at 10; 18 U.S.C. § 2340(2)(B).

With respect to the small confinement box, you have informed us that he would spend at most two hours in this box. You have informed us that your purpose in using these boxes is not to interfere with his senses or his personality, but to cause him physical discomfort that will encourage him to disclose critical information. Moreover, your imposition of time limitations on the use of either of the boxes also indicates that the use of these boxes is not designed or calculated to disrupt profoundly the senses or personality. For the larger box, in which he can

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both stand and sit, he may be placed in this box for up to eighteen hours at a time, while you have informed us that he will never spend more than an hour at time in the smaller box. These time limits further ensure that no profound disruption of the senses or personality, were it even possible, would result. As such, the use of the confinement boxes does not constitute a procedure calculated to disrupt profoundly the senses or personality.

Nor does the use of the boxes threaten Zubaydah with severe physical pain or suffering. While additional time spent in the boxes may be threatened, their use is not accompanied by any express threats of severe physical pain or suffering. Like the stress positions and walling, placement in the boxes is physically uncomfortable but any such discomfort does not rise to the level of severe physical pain or suffering. Accordingly, a reasonable person in the subject's position would not infer from the use of this technique that severe physical pain is the next step in his interrogator's treatment of him. Therefore, we conclude that the use of the confinement boxes does not fall within the statute's required predicate acts.

In addition to using the confinement boxes alone, you also would like to introduce an insect into one of the boxes with Zubaydah. As we understand it, you plan to inform Zubaydah that you are going to place a stinging insect into the box, but you will actually place a harmless insect in the box, such as a caterpillar. If you do so, to ensure that you are outside the predicate act requirement, you must inform him that the insects will not have a sting that would produce death or severe pain. If, however, you were to place the insect in the box without informing him that you are doing so, then, in order to not commit a predicate act, you should not affirmatively lead him to believe that any insect is present which has a sting that could produce severe pain or suffering or even cause his death.

So long as you take either of the approaches we have described, the insect's placement in the box would not constitute a threat of severe physical pain or suffering to a reasonable person in his position. An individual placed in a box, even an individual with a fear of insects, would not reasonably feel threatened with severe physical pain or suffering if a caterpillar was placed in the box. Further, you have informed us that you are not aware that Zubaydah has any allergies to insects, and you have not informed us of any other factors that would cause a reasonable person in that same situation to believe that an unknown insect would cause him severe physical pain or death. Thus, we conclude that the placement of the insect in the confinement box with Zubaydah would not constitute a predicate act.

Sleep deprivation also clearly does not involve a threat of imminent death. Although it produces physical discomfort, it cannot be said to constitute a threat of severe physical pain or suffering from the perspective of a reasonable person in Zubaydah's position. Nor could sleep deprivation constitute a procedure calculated to disrupt profoundly the senses, so long as sleep deprivation (as you have informed us is your intent) is used for limited periods, before hallucinations or other profound disruptions of the senses would occur. To be sure, sleep deprivation may reduce the subject's ability to think on his feet. Indeed, you indicate that this is

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the intended result. His mere reduced ability to evade your questions and resist answering does not, however, rise to the level of disruption required by the statute. As we explained above, a disruption within the meaning of the statute is an extreme one, substantially interfering with an individual's cognitive abilities, for example, inducing hallucinations, or driving him to engage in uncharacteristic self-destructive behavior. See *infra* 13; Section 2340A Memorandum at 11. Therefore, the limited use of sleep deprivation does not constitute one of the required predicate acts.

We find that the use of the waterboard constitutes a threat of imminent death. As you have explained the waterboard procedure to us, it creates in the subject the uncontrollable physiological sensation that the subject is drowning. Although the procedure will be monitored by personnel with medical training and extensive SERE school experience with this procedure who will ensure the subject's mental and physical safety, the subject is not aware of any of these precautions. From the vantage point of any reasonable person undergoing this procedure in such circumstances, he would feel as if he is drowning at very moment of the procedure due to the uncontrollable physiological sensation he is experiencing. Thus, this procedure cannot be viewed as too uncertain to satisfy the imminence requirement. Accordingly, it constitutes a threat of imminent death and fulfills the predicate act requirement under the statute.

Although the waterboard constitutes a threat of imminent death, prolonged mental harm must nonetheless result to violate the statutory prohibition on infliction of severe mental pain or suffering. See Section 2340A Memorandum at 7. We have previously concluded that prolonged mental harm is mental harm of some lasting duration, e.g., mental harm lasting months or years. See *id.* Prolonged mental harm is not simply the stress experienced in, for example, an interrogation by state police. See *id.* Based on your research into the use of these methods at the SERE school and consultation with others with expertise in the field of psychology and interrogation, you do not anticipate that any prolonged mental harm would result from the use of the waterboard. Indeed, you have advised us that the relief is almost immediate when the cloth is removed from the nose and mouth. In the absence of prolonged mental harm, no severe mental pain or suffering would have been inflicted, and the use of these procedures would not constitute torture within the meaning of the statute.

When these acts are considered as a course of conduct, we are unsure whether these acts may constitute a threat of severe physical pain or suffering. You have indicated to us that you have not determined either the order or the precise timing for implementing these procedures. It is conceivable that these procedures could be used in a course of escalating conduct, moving incrementally and rapidly from least physically intrusive, e.g., facial hold, to the most physical contact, e.g., walling or the waterboard. As we understand it, based on his treatment so far, Zubaydah has come to expect that no physical harm will be done to him. By using these techniques in increasing intensity and in rapid succession, the goal would be to dislodge this expectation. Based on the facts you have provided to us, we cannot say definitively that the entire course of conduct would cause a reasonable person to believe that he is being threatened

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with severe pain or suffering within the meaning of section 2340. On the other hand, however, under certain circumstances—for example, rapid escalation in the use of these techniques culminating in the waterboard (which we acknowledge constitutes a threat of imminent death) accompanied by verbal or other suggestions that physical violence will follow—might cause a reasonable person to believe that they are faced with such a threat. Without more information, we are uncertain whether the course of conduct would constitute a predicate act under Section 2340(2).

Even if the course of conduct were thought to pose a threat of physical pain or suffering, it would nevertheless—on the facts before us—not constitute a violation of Section 2340A. Not only must the course of conduct be a predicate act, but also those who use the procedure must actually cause prolonged mental harm. Based on the information that you have provided to us, indicating that no evidence exists that this course of conduct produces any prolonged mental harm, we conclude that a course of conduct using these procedures and culminating in the waterboard would not violate Section 2340A.

Specific Intent. To violate the statute, an individual must have the specific intent to inflict severe pain or suffering. Because specific intent is an element of the offense, the absence of specific intent negates the charge of torture. As we previously opined, to have the required specific intent, an individual must expressly intend to cause such severe pain or suffering. See Section 2340A Memorandum at 3 citing *Carter v. United States*, 530 U.S. 255, 267 (2000). We have further found that if a defendant acts with the good faith belief that his actions will not cause such suffering, he has not acted with specific intent. See *id.* at 4 citing *South Atl. Lmt'd. Ptnshp. of Tenn. v. Reise*, 218 F.3d 518, 531 (4th Cir. 2002). A defendant acts in good faith when he has an honest belief that his actions will not result in severe pain or suffering. See *id.* citing *Cheek v. United States*, 498 U.S. 192, 202 (1991). Although an honest belief need not be reasonable, such a belief is easier to establish where there is a reasonable basis for it. See *id.* at 5. Good faith may be established by, among other things, the reliance on the advice of experts. See *id.* at 8.

Based on the information you have provided us, we believe that those carrying out these procedures would not have the specific intent to inflict severe physical pain or suffering. The objective of these techniques is not to cause severe physical pain. First, the constant presence of personnel with medical training who have the authority to stop the interrogation should it appear it is medically necessary indicates that it is not your intent to cause severe physical pain. The personnel on site have extensive experience with these specific techniques as they are used in SERE school training. Second, you have informed us that you are taking steps to ensure that Zubaydah's injury is not worsened or his recovery impeded by the use of these techniques.

Third, as you have described them to us, the proposed techniques involving physical contact between the interrogator and Zubaydah actually contain precautions to prevent any serious physical harm to Zubaydah. In "walling," a rolled hood or towel will be used to prevent

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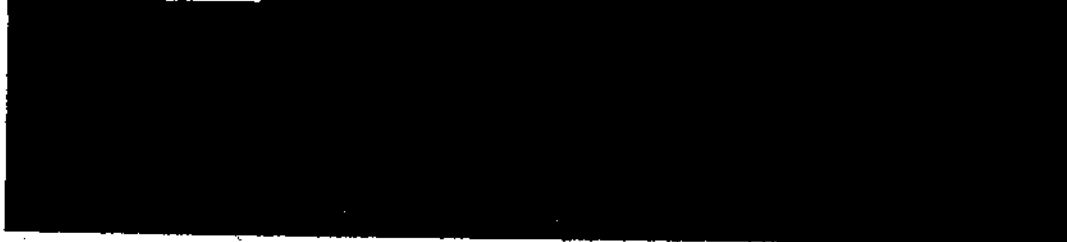
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whiplash and he will be permitted to rebound from the flexible wall to reduce the likelihood of injury. Similarly, in the "facial hold," the fingertips will be kept well away from the his eyes to ensure that there is no injury to them. The purpose of that facial hold is not injure him but to hold the head immobile. Additionally, while the stress positions and wall standing will undoubtedly result in physical discomfort by tiring the muscles, it is obvious that these positions are not intended to produce the kind of extreme pain required by the statute.

Furthermore, no specific intent to cause severe mental pain or suffering appears to be present. As we explained in our recent opinion, an individual must have the specific intent to cause prolonged mental harm in order to have the specific intent to inflict severe mental pain or suffering. See Section 2340A Memorandum at 8. Prolonged mental harm is substantial mental harm of a sustained duration, e.g., harm lasting months or even years after the acts were inflicted upon the prisoner. As we indicated above, a good faith belief can negate this element. Accordingly, if an individual conducting the interrogation has a good faith belief that the procedures he will apply, separately or together, would not result in prolonged mental harm, that individual lacks the requisite specific intent. This conclusion concerning specific intent is further bolstered by the due diligence that has been conducted concerning the effects of these interrogation procedures.

The mental health experts that you have consulted have indicated that the psychological impact of a course of conduct must be assessed with reference to the subject's psychological history and current mental health status. The healthier the individual, the less likely that the use of any one procedure or set of procedures as a course of conduct will result in prolonged mental harm. A comprehensive psychological profile of Zubaydah has been created. In creating this profile, your personnel drew on direct interviews, Zubaydah's diaries, observation of Zubaydah since his capture, and information from other sources such as other intelligence and press reports.



As we indicated above, you have informed us that your proposed interrogation methods have been used and continue to be used in SERE training. It is our understanding that these techniques are not used one by one in isolation, but as a full course of conduct to resemble a real interrogation. Thus, the information derived from SERE training bears both upon the impact of the use of the individual techniques and upon their use as a course of conduct. You have found that the use of these methods together or separately, including the use of the waterboard, has not resulted in any negative long-term mental health consequences. The continued use of these methods without mental health consequences to the trainees indicates that it is highly improbable

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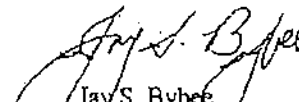
that such consequences would result here. Because you have conducted the due diligence to determine that these procedures, either alone or in combination, do not produce prolonged mental harm, we believe that you do not meet the specific intent requirement necessary to violate Section 2340A.

You have also informed us that you have reviewed the relevant literature on the subject, and consulted with outside psychologists. Your review of the literature uncovered no empirical data on the use of these procedures, with the exception of sleep deprivation for which no long-term health consequences resulted. The outside psychologists with whom you consulted indicated were unaware of any cases where long-term problems have occurred as a result of these techniques.

As described above, it appears you have conducted an extensive inquiry to ascertain what impact, if any, these procedures individually and as a course of conduct would have on Zubaydah. You have consulted with interrogation experts, including those with substantial SERE school experience, consulted with outside psychologists, completed a psychological assessment and reviewed the relevant literature on this topic. Based on this inquiry, you believe that the use of the procedures, including the waterboard, and as a course of conduct would not result in prolonged mental harm. Reliance on this information about Zubaydah and about the effect of the use of these techniques more generally demonstrates the presence of a good faith belief that no prolonged mental harm will result from using these methods in the interrogation of Zubaydah. Moreover, we think that this represents not only an honest belief but also a reasonable belief based on the information that you have supplied to us. Thus, we believe that the specific intent to inflict prolonged mental is not present, and consequently, there is no specific intent to inflict severe mental pain or suffering. Accordingly, we conclude that on the facts in this case the use of these methods separately or a course of conduct would not violate Section 2340A.

Based on the foregoing, and based on the facts that you have provided, we conclude that the interrogation procedures that you propose would not violate Section 2340A. We wish to emphasize that this is our best reading of the law; however, you should be aware that there are no cases construing this statute; just as there have been no prosecutions brought under it.

Please let us know if we can be of further assistance.

  
Jay S. Bybee  
Assistant Attorney General

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## Appendix D

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## Guidelines on Confinement Conditions For CIA Detainees

These Guidelines govern the conditions of confinement for CIA Detainees, who are persons detained in detention facilities that are under the [REDACTED] control of CIA ("Detention Facilities"). [REDACTED]

[REDACTED] These Guidelines recognize that environmental and other conditions, as well as particularized considerations affecting any given Detention Facility, will vary from case to case and location to location.

### 1. Minimums

Due provision must be taken to protect the health and safety of all CIA Detainees, including basic levels of medical care [REDACTED]

### 2. Implementing Procedures

a. [REDACTED]

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## Guidelines on Confinement Conditions for CIA Detainees

b. [REDACTED]

c. [REDACTED]

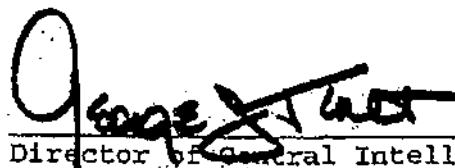
## 3. Responsible CIA Officer

The Director, DCI Counterterrorist Center shall ensure (a) that, at all times, a specific Agency staff employee (the "Responsible CIA Officer") is designated as responsible for each specific Detention Facility, (b) that each Responsible CIA Officer has been provided with a copy of these Guidelines and has reviewed and signed the attached Acknowledgment, and (c) that each Responsible CIA Officer and each CIA officer participating in the questioning of individuals detained pursuant to [REDACTED]

[REDACTED] has been provided with a copy of the "Guidelines on Interrogation Conducted Pursuant [REDACTED] and has reviewed and signed the Acknowledgment attached thereto. Subject to operational and security considerations, the Responsible CIA Officer shall be present at, or visit, each Detention Facility at intervals appropriate to the circumstances.

4. [REDACTED]

APPROVED:

  
Director of Central Intelligence

11/28/03  
Date

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## Guidelines on Confinement Conditions for CIA Detainees

ACKNOWLEDGMENT

I, \_\_\_\_\_, am the Responsible CIA Officer for the Detention Facility known as \_\_\_\_\_. By my signature below, I acknowledge that I have read and understand and will comply with the "Guidelines on Confinement Conditions for CIA Detainees" of \_\_\_\_\_, 2003.

ACKNOWLEDGED:

\_\_\_\_\_  
Name\_\_\_\_\_  
Date

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## Appendix E



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# Guidelines on Interrogations Conducted Pursuant to the

  
[REDACTED]

These Guidelines address the conduct of interrogations of persons who are detained pursuant to the authorities set forth in [REDACTED]

  
[REDACTED]

These Guidelines complement internal Directorate of Operations guidance relating to the conduct of interrogations. In the event of any inconsistency between existing DO guidance and these Guidelines, the provisions of these Guidelines shall control.

## 1. Permissible Interrogation Techniques

Unless otherwise approved by Headquarters, CIA officers and other personnel acting on behalf of CIA may use only Permissible Interrogation Techniques. Permissible Interrogation Techniques consist of both (a) Standard Techniques and (b) Enhanced Techniques.

Standard Techniques are techniques that do not incorporate physical or substantial psychological pressure. These techniques include, but are not limited to, all lawful forms of questioning employed by US law enforcement and military interrogation personnel. Among Standard Techniques are the use of isolation, sleep deprivation not to exceed 72 hours, reduced caloric intake (so long as the amount is calculated to maintain the general health of the detainee), deprivation of reading material, use of loud music or white noise (at a decibel level calculated to avoid damage to the detainee's hearing), and the use of diapers for limited periods (generally not to exceed 72 hours, [REDACTED])

  
[REDACTED]

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THIS DOCUMENT ARE  
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## Guideline on Interrogations Conducted Pursuant to the [REDACTED]

Enhanced Techniques are techniques that do incorporate physical or psychological pressure beyond Standard Techniques. The use of each specific Enhanced Technique must be approved by Headquarters in advance, and may be employed only by approved interrogators for use with the specific detainee, with appropriate medical and psychological participation in the process. These techniques are, the attention grasp, walling, the facial hold, the facial slap (insult slap), the abdominal slap, cramped confinement, wall standing, stress positions, sleep deprivation beyond 72 hours, the use of diapers for prolonged periods, the use of harmless insects, the water board, and such other techniques as may be specifically approved pursuant to paragraph 4 below. The use of each Enhanced Technique is subject to specific temporal, physical, and related conditions, including a competent evaluation of the medical and psychological state of the detainee.

## 2. Medical and Psychological Personnel

Appropriate medical and psychological personnel shall be [REDACTED] readily available for consultation and travel to the interrogation site during all detainee interrogations employing Standard Techniques, and appropriate medical and psychological personnel must be on site during all detainee interrogations employing Enhanced Techniques. In each case, the medical and psychological personnel shall suspend the interrogation if they determine that significant and prolonged physical or mental injury, pain, or suffering is likely to result if the interrogation is not suspended. In any such instance, the interrogation team shall immediately report the facts to Headquarters for management and legal review to determine whether the interrogation may be resumed.

## 3. Interrogation Personnel

The Director, DCI Counterterrorist Center shall ensure that all personnel directly engaged in the interrogation of persons detained pursuant [REDACTED] have been appropriately screened (from the medical, psychological, and security standpoints), have reviewed these Guidelines, have received appropriate training in their implementation, and have completed the attached Acknowledgment.

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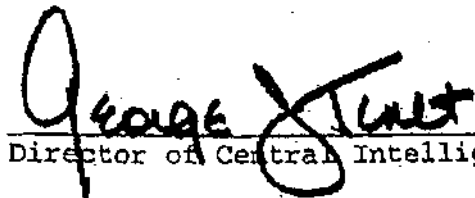
~~TOP SECRET~~ [REDACTED]Guideline on Interrogations Conducted Pursuant to the  
[REDACTED]**4. Approvals Required**

Whenever feasible, advance approval is required for the use of Standard Techniques by an interrogation team. In all instances, their use shall be documented in cable traffic. Prior approval in writing (e.g., by written memorandum or in cable traffic) from the Director, DCI Counterterrorist Center, with the concurrence of the Chief, CTC Legal Group, is required for the use of any Enhanced Technique(s), and may be provided only where D/CTC has determined that (a) the specific detainee is believed to possess information about risks to the citizens of the United States or other nations, (b) the use of the Enhanced Technique(s) is appropriate in order to obtain that information, (c) appropriate medical and psychological personnel have concluded that the use of the Enhanced Technique(s) is not expected to produce "severe physical or mental pain or suffering," and (d) the personnel authorized to employ the Enhanced Technique(s) have completed the attached Acknowledgment. Nothing in these Guidelines alters the right to act in self-defense.

**5. Recordkeeping**

In each interrogation session in which an Enhanced Technique is employed, a contemporaneous record shall be created setting forth the nature and duration of each such technique employed, the identities of those present, and a citation to the required Headquarters approval cable. This information, which may be in the form of a cable, shall be provided to Headquarters.

APPROVED:

  
Director of Central Intelligence

January 28, 2003  
Date

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Guideline on Interrogations Conducted Pursuant to the  
[REDACTED]

ACKNOWLEDGMENT

I, \_\_\_\_\_, acknowledge that I have read and  
understand and will comply with the "Guidelines on  
Interrogations Conducted Pursuant to \_\_\_\_\_  
\_\_\_\_\_ of \_\_\_\_\_,  
2003.

ACKNOWLEDGED:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

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## Appendix F

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## DRAFT OMS GUIDELINES ON MEDICAL AND PSYCHOLOGICAL SUPPORT TO DETAINEE INTERROGATIONS

September 4, 2003

The following guidelines offer general references for medical officers supporting the detention of terrorists captured and turned over to the Central Intelligence Agency for interrogation and debriefing. There are three different contexts in which these guidelines may be applied: (1) during the period of initial interrogation, (2) during the more sustained period of debriefing at an interrogation site, and (3) [REDACTED]

### INTERROGATION SUPPORT

Captured terrorists turned over to the C.I.A. for interrogation may be subjected to a wide range of legally sanctioned techniques, all of which are also used on U.S. military personnel in SERE training programs. These are designed to psychologically "dislocate" the detainee, maximize his feeling of vulnerability and helplessness, and reduce or eliminate his will to resist our efforts to obtain critical intelligence.

Sanctioned interrogation techniques must be specifically approved in advance by the Director, CTC in the case of each individual case. They include, in approximately ascending degree of intensity:

Standard measures (i.e., without physical or substantial psychological pressure)

- Shaving
- Stripping
- Diapering (generally for periods not greater than 72 hours)
- Hooding
- Isolation
- White noise or loud music (at a decibel level that will not damage hearing)
- Continuous light or darkness
- Uncomfortably cool environment
- Restricted diet, including reduced caloric intake (sufficient to maintain general health)
- Shackling in upright, sitting, or horizontal position
- Water Dousing
- Sleep deprivation (up to 72 hours)

Enhanced measures (with physical or psychological pressure beyond the above)

- Attention grasp
- Facial hold
- Insult (facial) slap

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Abdominal slap  
 Prolonged diapering  
 Sleep deprivation (over 72 hours)  
 Stress positions  
     --on knees, body slanted forward or backward  
     --leaning with forehead on wall  
 Walling  
 Cramped confinement (Confinement boxes)  
 Waterboard

In all instances the general goal of these techniques is a psychological impact, and not some physical effect, with a specific goal of "dislocat[ing] his expectations regarding the treatment he believes he will receive...." The more physical techniques are delivered in a manner carefully limited to avoid serious physical harm. The slaps for example are designed "to induce shock, surprise, and/or humiliation" and "not to inflict physical pain that is severe or lasting." To this end they must be delivered in a specifically circumscribed manner, e.g., with fingers spread. Walling is only against a springboard designed to be loud and bouncy (and cushion the blow). All walling and most attention grasps are delivered only with the subject's head solidly supported with a towel to avoid extension-flexion injury.

OMS is responsible for assessing and monitoring the health of all Agency detainees subject to "enhanced" interrogation techniques, and for determining that the authorized administration of these techniques would not be expected to cause serious or permanent harm.<sup>1</sup> "DCI Guidelines" have been issued formalizing these responsibilities, and these should be read directly.

Whenever feasible, advance approval is required to use any measures beyond standard measures; technique-specific advanced approval is required for all "enhanced" measures and is conditional on on-site medical and psychological personnel<sup>2</sup> confirming from direct detainee examination that the enhanced technique(s) is not expected to produce "severe physical or mental pain or suffering." As a practical matter, the detainee's physical condition must be such that these interventions will not have lasting

<sup>1</sup> The standard used by the Justice Department for "mental" harm is "prolonged mental harm," i.e., "mental harm of some lasting duration, e.g., mental harm lasting months or years." "In the absence of prolonged mental harm, no severe mental pain or suffering would have been inflicted." Memorandum of August 1, 2002, p. 15.

<sup>2</sup> [REDACTED]  
 Unless the waterboard is being used, the medical officer can be a physician or a PA; use of the waterboard requires the presence of a physician.

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effect, and his psychological state strong enough that no severe psychological harm will result.

The medical implications of the DCI guidelines are discussed below.

#### General intake evaluation

New detainees are to have a thorough initial medical assessment, with a complete, documented history and physical addressing in depth any chronic or previous medical problems. [REDACTED]

Vital signs and weight should be recorded, and blood work drawn [REDACTED]

Documented subsequent medical rechecks should be performed on a regular basis, [REDACTED]

Although brief, the data should reflect what was checked and include negative findings. [REDACTED]

#### Medical treatment

It is important that adequate medical care be provided to detainees, even those undergoing enhanced interrogation. Those requiring chronic medications should receive them, acute medical problems should be treated, and adequate fluids and nutrition provided. [REDACTED]

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[REDACTED]

The basic diet during the period of enhanced interrogation need not be palatable, but should include adequate fluids and nutrition. Actual consumption should be monitored and recorded. Liquid Ensure (or equivalent) is a good way to assure that there is adequate nutrition. [REDACTED]

[REDACTED] Individuals refusing adequate liquids during this stage should have fluids administered at the earliest signs of dehydration. [REDACTED]

[REDACTED] If there is any question about adequacy of fluid intake, urinary output also should be monitored and recorded.

#### Uncomfortably cool environments

Detainees can safely be placed in uncomfortably cool environments for varying lengths of time, ranging from hours to days. [REDACTED]

[REDACTED]

Core body temperature falls after more than 2 hours at an ambient temperature of 10°C/50°F. At this temperature increased metabolic rate cannot compensate for heat loss. The WHO recommended minimum indoor temperature is 18°C/64°F. The "thermoneutral zone" where minimal compensatory activity is required to maintain core temperature is 20°C/68°F to 30°C/86°F. Within the thermoneutral zone, 26°C/78°F is considered optimally comfortable for lightly clothed individuals and 30°C/86°F for naked individuals. [REDACTED]

[REDACTED]

If there is any possibility that ambient temperatures are below the thermoneutral range, they should be monitored and the actual temperatures documented. [REDACTED]

[REDACTED]

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At ambient temperatures below 18°C/64°F, detainees should be monitored for the development of hypothermia. [REDACTED]

#### White noise or loud music

As a practical guide, there is no permanent hearing risk for continuous, 24-hours-a-day exposures to sound at 82 dB or lower; at 84 dB for up to 18 hours a day; 90 dB for up to 8 hours, 95 dB for 4 hours, and 100 dB for 2 hours. If necessary, instruments can be provided to measure these ambient sound levels. [REDACTED]

#### Shackling

Shackling in non-stressful positions requires only monitoring for the development of pressure sores with appropriate treatment and adjustment of the shackles as required. [REDACTED]

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[REDACTED]

[REDACTED]

Assuming no medical contraindications are found, extended periods (up to 72 hours) in a standing position can be approved if the hands are no higher than head level and weight is borne fully by the lower extremities. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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~~TOP SECRET~~ [REDACTED]Sleep deprivation

[REDACTED]

The standard approval for sleep deprivation, per se (without regard to shackling position) is 72 hours. Extension of sleep deprivation beyond 72 continuous hours is considered an enhanced measure, which requires D/CTC prior approval.

[REDACTED]

*NOTE: Examinations performed during periods of sleep deprivation should include the current number of hours without sleep; and, if only a brief rest preceded this period, the specifics of the previous deprivation also should be recorded.*

Cramped confinement (Confinement boxes)

Detainees can be placed in awkward boxes, specifically constructed for this purpose.

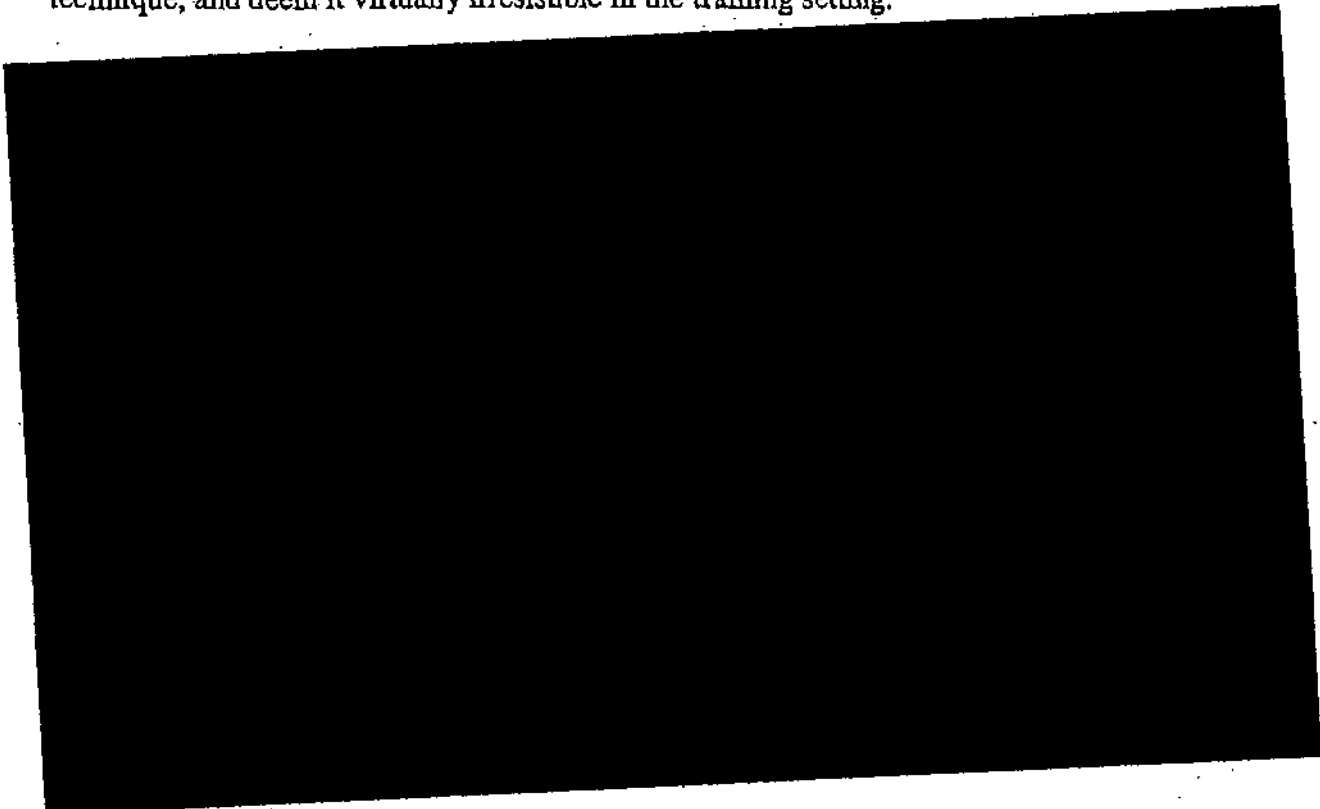

[REDACTED]

[REDACTED] confinement in the small box is allowable up to 2 hours. Confinement in the large box is limited to 8 consecutive hours, [REDACTED]

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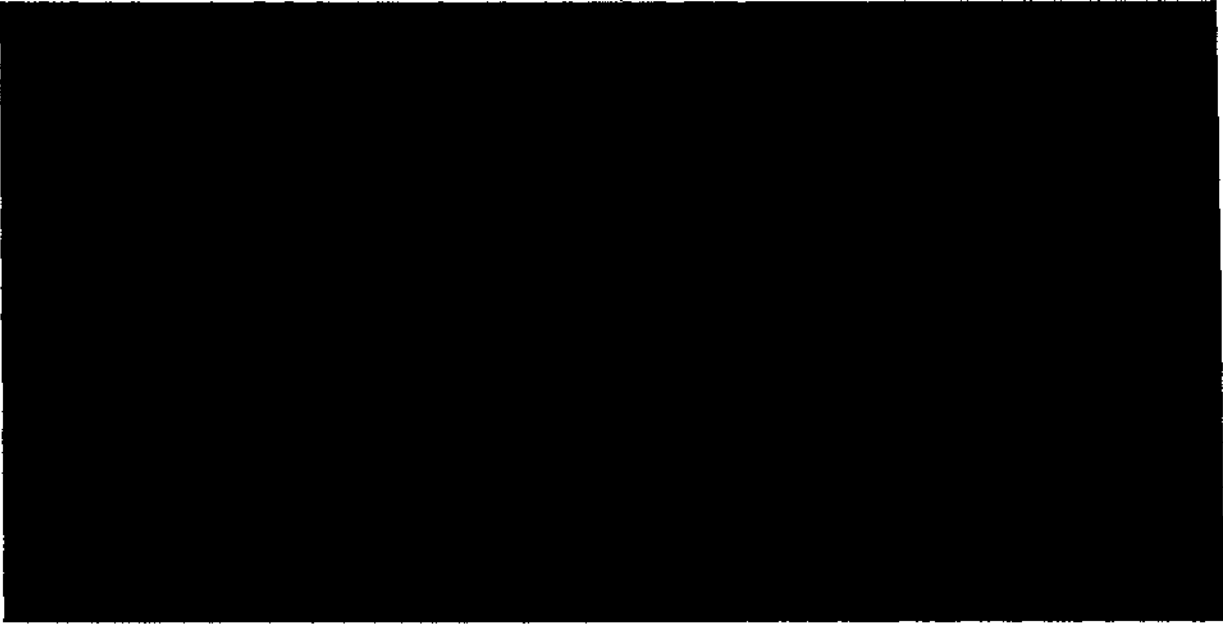
~~TOP SECRET~~ Waterboard

This is by far the most traumatic of the enhanced interrogation techniques. The historical context here was limited knowledge of the use of the waterboard in SERE training (several hundred trainees experience it every year or two). In the SERE model the subject is immobilized on his back, and his forehead and eyes covered with a cloth. A stream of water is directed at the upper lip. Resistant subjects then have the cloth lowered to cover the nose and mouth, as the water continues to be applied, fully saturating the cloth, and precluding the passage of air. Relatively little water enters the mouth. The occlusion (which may be partial) lasts no more than 20 seconds. On removal of the cloth, the subject is immediately able to breathe, but continues to have water directed at the upper lip to prolong the effect. This process can continue for several minutes, and involve up to 15 canteen cups of water. Ostensibly the primary desired effect derives from the sense of suffocation resulting from the wet cloth temporarily occluding the nose and mouth, and psychological impact of the continued application of water after the cloth is removed. SERE trainees usually have only a single exposure to this technique, and never more than two; SERE trainers consider it their most effective technique, and deem it virtually irresistible in the training setting.

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The SERE training program has applied the waterboard technique (single exposure) to trainees for years, and reportedly there have been thousands of applications without significant or lasting medical complications. The procedure nonetheless carries some risks, particularly when repeated a large number of times or when applied to an individual less fit than a typical SERE trainee. Several medical dimensions need to be monitored to ensure the safety of the subject.



In our limited experience, extensive sustained use of the waterboard can introduce new risks. Most seriously, for reasons of physical fatigue or psychological resignation, the subject may simply give up, allowing excessive filling of the airways and loss of consciousness. An unresponsive subject should be righted immediately, and the interrogator should deliver a sub-xiphoid thrust to expel the water. If this fails to restore normal breathing, aggressive medical intervention is required. Any subject who has reached this degree of compromise is not considered an appropriate candidate for the waterboard, and the physician on the scene can not approve further use of the waterboard without specific C/OMS consultation and approval.

A rigid guide to medically approved use of the waterboard in essentially healthy individuals is not possible, as safety will depend on how the water is applied and the specific response each time it is used. The following general guidelines are based on very limited knowledge, drawn from very few subjects whose experience and response was quite varied. These represent only the medical guidelines; legal guidelines also are operative and may be more restrictive.

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A series (within a "session") of several relatively rapid waterboard applications is medically acceptable in all healthy subjects, so long as there is no indication of some emerging vulnerability [REDACTED]

[REDACTED] Several such sessions per 24 hours have been employed without apparent medical complication. The exact number of sessions cannot be prescribed, and will depend on the response to each. If more than 3 sessions of 5 or more applications are envisioned within a 24 hours period, a careful medical reassessment must be made before each later session.

By days 3-5 of an aggressive program, cumulative effects become a potential concern. Without any hard data to quantify either this risk or the advantages of this technique, we believe that beyond this point continued intense waterboard applications may not be medically appropriate. Continued aggressive use of the waterboard beyond this point should be reviewed by the HVT team in consultation with Headquarters prior to any further aggressive use. [REDACTED]

*NOTE: In order to best inform future medical judgments and recommendations, it is important that every application of the waterboard be thoroughly documented: how long each application (and the entire procedure) lasted, how much water was used in the process (realizing that much splashes off), how exactly the water was applied, if a seal was achieved, if the naso- or oropharynx was filled, what sort of volume was expelled, how long was the break between applications, and how the subject looked between each treatment.*

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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OFFICE OF THE UNITED NATIONS  
HIGH COMMISSIONER FOR HUMAN RIGHTS  
Geneva



**PROFESSIONAL TRAINING SERIES No. 8/Rev.1**

# **Istanbul Protocol**

*Manual on the Effective Investigation and  
Documentation of Torture and Other Cruel,  
Inhuman or Degrading Treatment or Punishment*



**UNITED NATIONS  
New York and Geneva, 2004**

**NOTE**

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Manual on the Effective Investigation and Documentation of Torture and  
Other Cruel, Inhuman or Degrading Treatment or Punishment

**Istanbul Protocol**

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United Nations High Commissioner for Human Rights

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## INTRODUCTION

Torture is defined in this manual in the words of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984:

[T]orture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person, has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.<sup>1</sup>

Torture is a profound concern of the world community. Its purpose is to destroy deliberately not only the physical and emotional well-being of individuals but also, in some instances, the dignity and will of entire communities. It concerns all members of the human family because it impugns the very meaning of our existence and our hopes for a brighter future.<sup>2</sup>

Although international human rights and humanitarian law consistently prohibit torture under any circumstance (see chapter I), torture and ill-treatment are practised in more than half of the world's countries.<sup>3,4</sup> The striking disparity between the absolute prohibition of torture and its prevalence in the world today demonstrates the need for States to identify and implement effective measures to protect individuals from torture and ill-treatment. This manual was developed to enable States to address one of the most fundamental concerns in protecting individuals from torture—effective documentation. Such documentation brings evidence of torture and ill-treatment to light so that perpetrators may be held accountable for their actions and the interests of justice may be served. The documentation methods contained in this manual are also applicable to other contexts, including human rights investigations and monitoring, political asylum evaluations, the defence of individuals who “confess” to crimes during torture and needs assessments for the care of torture victims, among others. In the case of health professionals who are coerced into neglect, misrepresentation or falsification of evidence of torture, this manual also provides an international point of reference for health professionals and adjudicators alike.

During the past two decades, much has been learned about torture and its consequences, but no international guidelines for documentation were available prior to the development of this manual. The *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* is intended to serve as international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting findings to the judiciary or any other investigative body. This manual includes principles for the effective investigation and documentation of torture,

<sup>1</sup> Since 1982, the recommendations concerning United Nations assistance to victims of torture made by the Board of Trustees of the United Nations Voluntary Fund for Victims of Torture to the Secretary-General of the United Nations, are based on article 1 of the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which provides that “Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment” and that “It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners”, as well as on all other relevant international instruments.

<sup>2</sup> V. Iacopino, “Treatment of survivors of political torture: commentary”, *The Journal of Ambulatory Care Management*, vol. 21 (2) (1998), pp. 5-13.

<sup>3</sup> Amnesty International, *Amnesty International Report 1999* (London, AIP, 1999).

<sup>4</sup> M. Başoglu, “Prevention of torture and care of survivors: an integrated approach”, *The Journal of the American Medical Association (JAMA)*, vol. 270 (1993), pp. 606-611.

and other cruel, inhuman or degrading treatment or punishment (see annex I). These principles outline minimum standards for States in order to ensure the effective documentation of torture.<sup>5</sup> The guidelines contained in this manual are not presented as a fixed protocol. Rather, they represent minimum standards based on the principles and should be used taking into account available resources. The manual and principles are the result of three years of analysis, research and drafting, undertaken by more than 75 experts in law, health and human rights, representing 40 organizations or institutions from 15 countries. The conceptualization and preparation of this manual was a collaborative effort between forensic scientists, physicians, psychologists, human-rights monitors and lawyers working in Chile, Costa Rica, Denmark, France, Germany, India, Israel, the Netherlands, South Africa, Sri Lanka, Switzerland, Turkey, the United Kingdom, the United States of America, and the occupied Palestinian territories.

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<sup>5</sup> The Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment are annexed to General Assembly resolution 55/89 of 4 December 2000 and to Commission on Human Rights resolution 2000/43 of 20 April 2000, both adopted without a vote.

## CHAPTER I

## RELEVANT INTERNATIONAL LEGAL STANDARDS

1. The right to be free from torture is firmly established under international law. The Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment all expressly prohibit torture. Similarly, several regional instruments establish the right to be free from torture. The American Convention on Human Rights, the African Charter on Human and Peoples' Rights and the European Convention for the Protection of Human Rights and Fundamental Freedoms all contain express prohibitions of torture.

#### A. International humanitarian law

2. The international treaties governing armed conflicts establish international humanitarian law or the law of war. The prohibition of torture under international humanitarian law is only a small, but important, part of the wider protection these treaties provide for all victims of war. The four Geneva Conventions of 1949 have been ratified by 188 States. They establish rules for the conduct of international armed conflict and, especially, for the treatment of persons who do not, or who no longer, take part in hostilities, including the wounded, the captured and civilians. All four conventions prohibit the infliction of torture and other forms of ill-treatment. Two Protocols of 1977, additional to the Geneva Conventions, expand the protection and scope of these conventions. Protocol I (ratified to date by 153 States) covers international conflicts. Protocol II (ratified to date by 145 States) covers non-international conflicts.

3. More important to the purpose here, however, is what is known as "Common Article 3", found in all four conventions. Common Article 3 applies to armed conflicts "not of an international character", no further definition being given. It is taken to define core obligations that must be respected in all armed conflicts and not just in international wars between countries. This is generally taken to mean that no matter what the nature of a war or conflict, certain basic rules cannot be abrogated. The prohibition of torture is one of these and represents an element common to international humanitarian law and human rights law.

#### 4. Common Article 3 states:

... the following acts are and shall remain prohibited at any time and in any place whatsoever... violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; ... outrages upon personal dignity, in particular humiliating and degrading treatment...

5. As the Special Rapporteur on the question of torture, Nigel Rodley, has stated:

The prohibition of torture or other ill-treatment could hardly be formulated in more absolute terms. In the words of the official commentary on the text by the International Committee of the Red Cross (ICRC), no possible loophole is left; there can be no excuse, no attenuating circumstances.<sup>6</sup>

6. A further link between international humanitarian law and human rights law is found in the preamble to Protocol II, which itself regulates non-international armed conflicts (such as fully-fledged civil wars), and which states that: "... international instruments relating to human rights offer a basic protection to the human person."<sup>7</sup>

#### B. The United Nations

7. The United Nations has sought for many years to develop universally applicable standards to ensure adequate protection for all persons against torture or cruel, inhuman or degrading treatment. The conventions, declarations and resolutions adopted by the Member States of the United Nations clearly state that there may be no exception to the prohibition of torture and establish other obligations to ensure protection against such abuses. Among the most important of these instruments are the Universal Declaration of Human Rights,<sup>8</sup> the International Covenant on Civil and Political Rights,<sup>9</sup> the Standard Minimum Rules for the Treatment of Prisoners,<sup>10</sup> the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Declaration on the Protection against Torture),<sup>11</sup> the Code of Conduct on

<sup>6</sup> N. Rodley, *The Treatment of Prisoners under International Law*, 2nd ed. (Oxford, Clarendon Press, 1999), p. 58.

<sup>7</sup> Second preambular paragraph of Protocol II (1977), additional to the Geneva Conventions of 1949.

<sup>8</sup> General Assembly resolution 217 A (III) of 10 December 1948, art. 5; see *Official Records of the General Assembly, Third Session* (A/810), p. 71.

<sup>9</sup> Entered into force on 23 March 1976; see General Assembly resolution 2200 A (XXI), of 16 December 1966, annex, art. 7; *Official Records of the General Assembly, Twenty-first Session, Supplement No. 16* (A/6316), p. 52, and United Nations, *Treaty Series*, vol. 999, p. 171.

<sup>10</sup> Adopted on 30 August 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders.

<sup>11</sup> General Assembly resolution 3452 (XXX) of 9 December 1975, annex, arts. 2 and 4; see *Official Records of the General Assembly, Thirtieth Session, Supplement No. 34* (A/10034), p. 91.

Law Enforcement,<sup>12</sup> the Principles of Medical Ethics Relevant to the Role of Health Personnel Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Principles of Medical Ethics),<sup>13</sup> the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture),<sup>14</sup> the Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment (Body of Principles on Detention)<sup>15</sup> and the Basic Principles for the Treatment of Prisoners.<sup>16</sup>

8. The United Nations Convention against Torture does not cover pain or suffering arising only from, inherent in or incidental to lawful sanctions.<sup>17</sup>

9. Other United Nations human rights bodies and mechanisms have taken action to develop standards for the prevention of torture and standards involving the obligation of States to investigate allegations of torture. These bodies and mechanisms include the Committee against Torture, the Human Rights Committee, the Commission on Human Rights, the Special Rapporteur on the question of torture, the Special Rapporteur on violence against women and country-specific special rapporteurs appointed by the Commission on Human Rights.

#### 1. *Legal obligations to prevent torture*

10. The international instruments cited above establish certain obligations that States must respect to ensure protection against torture. These include:

(a) Taking effective legislative, administrative, judicial or other measures to prevent acts of torture. No exceptions, including war, may be invoked as justification for torture (art. 2 of the Convention against Torture and

art. 3 of the Declaration on the Protection against Torture);

(b) Not expelling, returning (*refouler*) or extraditing a person to a country when there are substantial grounds for believing he or she would be tortured (art. 3 of the Convention against Torture);

(c) Criminalization of acts of torture, including complicity or participation therein (art. 4 of the Convention against Torture, principle 7 of the Body of Principles on Detention, art. 7 of the Declaration on the Protection against Torture and paras. 31-33 of the Standard Minimum Rules for the Treatment of Prisoners);

(d) Undertaking to make torture an extraditable offence and assisting other States parties in connection with criminal proceedings brought in respect of torture (arts. 8 and 9 of the Convention against Torture);

(e) Limiting the use of incommunicado detention; ensuring that detainees are held in places officially recognized as places of detention; ensuring the names of persons responsible for their detention are kept in registers readily available and accessible to those concerned, including relatives and friends; recording the time and place of all interrogations, together with the names of those present; and granting physicians, lawyers and family members access to detainees (art. 11 of the Convention against Torture; principles 11-13, 15-19 and 23 of the Body of Principles on Detention; paras. 7, 22 and 37 of the Standard Minimum Rules for the Treatment of Prisoners);

(f) Ensuring that education and information regarding the prohibition of torture is included in the training of law enforcement personnel (civil and military), medical personnel, public officials and other appropriate persons (art. 10 of the Convention against Torture, art. 5 of the Declaration on the Protection against Torture, para. 54 of the Standard Minimum Rules for the Treatment of Prisoners);

(g) Ensuring that any statement that is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made (art. 15 of the Convention against Torture, art. 12 of the Declaration on the Protection against Torture);

(h) Ensuring that the competent authorities undertake a prompt and impartial investigation, whenever there are reasonable grounds to believe that torture has been committed (art. 12 of the Convention against Torture, principles 33 and 34 of the Body of Principles on Detention, art. 9 of the Declaration on the Protection against Torture);

(i) Ensuring that victims of torture have the right to redress and adequate compensation (arts. 13 and 14 of the Convention against Torture, art. 11 of the Declaration on the Protection against Torture, paras. 35 and 36 of the Standard Minimum Rules for the Treatment of Prisoners);

(j) Ensuring that the alleged offender or offenders is subject to criminal proceedings if an investigation establishes that an act of torture appears to have been committed.

<sup>12</sup> General Assembly resolution 34/169 of 17 December 1979, annex, art. 5; see *Official Records of the General Assembly, Thirty-fourth Session, Supplement No. 46 (A/34/46)*, p. 186.

<sup>13</sup> General Assembly resolution 37/194 of 18 December 1982, annex, principles 2-5; see *Official Records of the General Assembly, Thirty-seventh Session, Supplement No. 51 (A/37/51)*, p. 211.

<sup>14</sup> Entered into force on 26 June 1987; see General Assembly resolution 39/46 of 10 December 1984, annex, art. 2, *Official Records of the General Assembly, Thirty-ninth Session, Supplement No. 51 (A/39/51)*, p. 197.

<sup>15</sup> General Assembly resolution 43/173 of 9 December 1988, annex, principle 6; see *Official Records of the General Assembly, Forty-third Session, Supplement No. 49 (A/43/49)*, p. 298.

<sup>16</sup> General Assembly resolution 45/111 of 14 December 1990, annex, principle 1; see *Official Records of the General Assembly, Forty-fifth Session, Supplement No. 49 (A/45/49)*, p. 200.

<sup>17</sup> For an interpretation of what constitutes "lawful sanctions", see the report of the Special Rapporteur on torture to the fifty-third session of the Commission on Human Rights (E/CN.4/1997/7, paras. 3-11), in which the Special Rapporteur expressed the view that the administration of punishments such as stoning to death, flogging and amputation cannot be deemed lawful simply because the punishment has been authorized in a procedurally legitimate manner. The interpretation put forward by the Special Rapporteur, which is consistent with the positions of the Human Rights Committee and other United Nations mechanisms, was endorsed by resolution 1998/38 of the Commission on Human Rights, which "[r]eminds Governments that corporal punishment can amount to cruel, inhuman or degrading treatment or even to torture".

ted. If an allegation of other forms of cruel, inhuman or degrading treatment or punishment is considered to be well founded, the alleged offender or offenders shall be subject to criminal, disciplinary or other appropriate proceedings (art. 7 of the Convention against Torture, art. 10 of the Declaration on the Protection against Torture).

## 2. *United Nations bodies and mechanisms*

### (a) *Committee against Torture*

11. The Committee against Torture monitors implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Committee consists of 10 experts appointed because of their "high moral standing and recognized competence in the field of human rights". Under article 19 of the Convention against Torture, the States parties submit to the Committee, through the Secretary-General, reports on the measures they have taken to give effect to their undertakings under the Convention. The Committee examines how the provisions of the Convention have been incorporated into domestic law and monitors how this functions in practice. Each report is considered by the Committee, which may make general comments and recommendations and include this information in its annual report to the States parties and to the General Assembly. These procedures take place in public meetings.

12. Under article 20 of the Convention against Torture, if the Committee receives reliable information that appears to contain well-founded indications that torture is being systematically practised in the territory of a State party, the Committee must invite that State party to cooperate in the examination of the information and, to this end, to submit observations with regard to the information concerned. The Committee may, if it decides that this is warranted, designate one or more of its members to make a confidential inquiry and to report to the Committee urgently. In agreement with that State party, that inquiry may include a visit to its territory. After examining the findings of its member or members, the Committee transmits these findings to the State party concerned together with any comments or suggestions that seem appropriate in view of the situation. All the proceedings of the Committee under article 20 are confidential, and, at all stages of the proceedings, the cooperation of the State party is sought. After completion of these proceedings, the Committee may, after consultations with the State party concerned, decide to include a summary account of the results of the proceedings in its annual report to the other States parties and to the General Assembly.<sup>18</sup>

13. Under article 22 of the Convention against Torture, a State party may at any time recognize the competence of the Committee to receive and consider individual complaints from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation by a State party of the provisions of the Convention against Torture. The Committee then considers these communications confidentially and shall forward its view to the State

party concerned and to the individual. Only 39 of the 112 States parties that have ratified the Convention have also recognized the applicability of article 22.

14. Among the concerns addressed by the Committee in its annual reports to the General Assembly is the necessity of States parties to comply with articles 12 and 13 on the Convention against Torture to ensure that prompt and impartial investigations of all complaints of torture are undertaken. For example, the Committee has stated that it considers a delay of 15 months in investigating allegations of torture to be unreasonably long and not in compliance with article 12.<sup>19</sup> The Committee has also noted that article 13 does not require a formal submission of a complaint of torture, but that "[i]t is sufficient for torture only to have been alleged by the victim for [a State Party] to be under an obligation promptly and impartially to examine the allegation".<sup>20</sup>

### (b) *Human Rights Committee*

15. The Human Rights Committee was established pursuant to article 28 of the International Covenant on Civil and Political Rights and the requirement to monitor implementation of the Covenant in the States parties. The Committee is composed of 18 independent experts who are expected to be persons of high moral character and of recognized competence in the field of human rights.

16. States parties to the Covenant must submit reports every five years on the measures they have adopted to give effect to the rights recognized in the Covenant and on progress made in the enjoyment of those rights. The Human Rights Committee examines the reports through a dialogue with representatives of the State party whose report is under consideration. The Committee then adopts concluding observations summarizing its main concerns and making appropriate suggestions and recommendations to the State party. The Committee also prepares general comments interpreting specific articles of the Covenant to guide States parties in their reporting, as well as their implementation of the Covenant's provisions. In one such general comment, the Committee undertook to clarify article 7 of the International Covenant on Civil and Political Rights, which states that no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment. In the general comments on article 7 of the Covenant in the report of the Committee, it specifically noted that prohibiting torture or making it a crime was not sufficient implementation of article 7.<sup>21</sup> The Committee stated: "... States must ensure an effective protection through some machinery of control. Complaints about ill-treatment must be investigated effectively by competent authorities."

17. On 10 April 1992, the Committee adopted new general comments on article 7, further developing the previous comments. The Committee reinforced its reading of article 7 by stating that "[c]omplaints must be investi-

<sup>18</sup> It should be pointed out, however, that application of article 20 can be limited because of a reservation by a State party, in which case article 20 is not applicable.

<sup>19</sup> See Communication 8/1991, para. 185, Report of the Committee against Torture to the General Assembly (A/49/44) of 12 June 1994.

<sup>20</sup> See Communication 6/1990, para. 10.4, Report of the Committee against Torture to the General Assembly (A/50/44) of 26 July 1995.

<sup>21</sup> United Nations, document A/37/40 (1982).

gated promptly and impartially by competent authorities so as to make the remedy effective". Where a State has ratified the first Optional Protocol to the International Covenant on Civil and Political Rights, an individual may submit a communication to the Committee complaining that his rights under the Covenant have been violated. If found admissible, the Committee issues a decision on the merits, which is made public in its annual report.

(c) *Commission on Human Rights*

18. The Commission on Human Rights is the primary human rights body of the United Nations. It is composed of 53 Member States elected by the Economic and Social Council for three-year terms. The Commission meets annually for six weeks in Geneva to act on human rights issues. The Commission may initiate studies and fact-finding missions, draft conventions and declarations for approval by higher United Nations bodies and discuss specific human rights violations in public or private sessions. On 6 June 1967, the Economic and Social Council, in resolution 1235, authorized the Commission to examine allegations of gross violations of human rights and to "make a thorough study of situations which reveal a consistent pattern of violations of human rights".<sup>22</sup> Under this mandate, the Commission has, among other procedures, adopted resolutions expressing concern about human rights violations and has appointed special rapporteurs to address human rights violations falling under a particular theme. The Commission has also adopted resolutions regarding torture and other cruel, inhuman or degrading treatment or punishment. In its resolution 1998/38, the Commission stressed that "all allegations of torture or cruel, inhuman or degrading treatment or punishment should be promptly and impartially examined by the competent national authority".

(d) *Special Rapporteur on the question of torture*

19. In 1985, the Commission decided, in resolution 1985/33, to appoint a Special Rapporteur on the question of torture. The Special Rapporteur is charged with seeking and receiving credible and reliable information on questions relevant to torture and to respond to that information without delay. The Commission has continued to renew the Special Rapporteur's mandate in subsequent resolutions.

20. The Special Rapporteur's authority to monitor extends to all Member States of the United Nations and to all States with observer status, regardless of the State's ratification of the Convention against Torture. The Special Rapporteur establishes contact with Governments, asks them for information on legislative and administrative measures taken to prevent torture, requests them to remedy any consequences and asks them to respond to information alleging the actual occurrence of torture. The Special Rapporteur also receives requests for urgent action, which he or she brings to the attention of the Governments concerned in order to ensure protection of an individual's right to physical and mental integrity. In addition, the Special Rapporteur holds consultations with gov-

ernment representatives who wish to meet with him or her and, in accordance with the position's mandate, makes *in situ* visits to some parts of the world. The Special Rapporteur submits reports to the Commission on Human Rights and to the General Assembly. These reports describe actions that the Special Rapporteur has taken under his or her mandate and persistently draw attention to the importance of prompt investigation of torture allegations. In the Report of the Special Rapporteur on the question of torture of 12 January 1995, the Special Rapporteur, Nigel Rodley, made a series of recommendations. In paragraph 926 (g) of the report, he stated:

When a detainee or relative or lawyer lodges a torture complaint, an inquiry should always take place... Independent national authorities, such as a national commission or ombudsman with investigatory and/or prosecutorial powers, should be established to receive and to investigate complaints. Complaints about torture should be dealt with immediately and should be investigated by an independent authority with no relation to that which is investigating or prosecuting the case against the alleged victim.<sup>23</sup>

21. The Special Rapporteur emphasized this recommendation in his report of 9 January 1996.<sup>24</sup> Discussing his concern about torture practices, the Special Rapporteur pointed out in paragraph 136 that "both under general international law and under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, States are obliged to investigate allegations of torture".

(e) *Special Rapporteur on violence against women*

22. The Special Rapporteur on violence against women was established in 1994 by resolution 1994/45 of the Commission on Human Rights and that mandate was renewed by resolution 1997/44. The Special Rapporteur has established procedures to seek clarification and information from Governments, in a humanitarian spirit, on specific cases of alleged violence in order to identify and investigate specific situations and allegations of violence against women in any country. These communications may concern one or more individuals identified by name or information of a more general nature relating to a prevailing situation condoning or perpetrating violence against women. The definition of gender-based violence against women used by the Special Rapporteur is taken from the Declaration on the Elimination of Violence against Women, adopted by the General Assembly in resolution 48/104 of 20 December 1993. Urgent appeals may be sent by the Special Rapporteur in cases of gender-based violence against women that involve or may involve an imminent threat or fear of threat to the right to life or physical integrity of a person. The Special Rapporteur urges the competent national authorities not only to provide comprehensive information on the case but also to carry out an independent and impartial investigation concerning the case transmitted and to take immediate action to ensure that no further violation of the human rights of women occur.

<sup>22</sup> Ibid., E/4393.

<sup>23</sup> Ibid., E/CN.4/1995/34.

<sup>24</sup> Ibid., E/CN.4/1996/35.

23. The Special Rapporteur reports annually to the Commission on Human Rights on communications sent to Governments and on replies received by him or her. On the basis of information received from Governments and other reliable sources, the Special Rapporteur makes recommendations to the Governments concerned with a view to finding durable solutions to the elimination of violence against women in any country. The Special Rapporteur may send follow-up communications to Governments when no replies have been received or when insufficient information has been provided. Should a particular situation of violence against women in any given country persist and information received by the Special Rapporteur indicate that no measures are or have been taken by a Government to ensure the protection of the human rights of women, the Special Rapporteur may consider the possibility of seeking permission from the Government concerned to visit that country in order to carry out an on-site fact-finding mission.

(f) *United Nations Voluntary Fund for Victims of Torture*

24. The physical and psychological after-effects of torture can be devastating and last for years, affecting not only the victims but also members of their families. Assistance in recovering from the trauma suffered can be obtained from organizations that specialize in assisting victims of torture. In December 1981, the General Assembly established the United Nations Voluntary Fund for Victims of Torture to receive voluntary contributions for distribution to non-governmental organizations (NGOs) that provide psychological, medical, social, economic, legal and other forms of humanitarian assistance to victims of torture and members of their families. Depending on the voluntary contributions available, the Fund may finance about 200 NGO projects assisting about 80,000 victims of torture and members of their families in about 80 countries worldwide. The Fund financed the drafting and translation of the present manual and recommended its publication in the Professional Training Series of the Office of the United Nations High Commissioner for Human Rights, following a recommendation of its Board of Trustees, which subsidizes a limited number of projects to train health professionals and others on how to provide specialized assistance to victims of torture.

### C. Regional organizations

25. Regional bodies have also contributed to the development of standards for the prevention of torture. These bodies include the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the European Court of Human Rights, the European Committee for the Prevention of Torture and the African Commission on Human Rights.

1. *The Inter-American Commission on Human Rights and the Inter-American Court of Human Rights*

26. On 22 November 1969, the Organization of American States adopted the American Convention on

Human Rights, which entered into force on 18 July 1978.<sup>25</sup> Article 5 of the Convention states:

1. Every person has the right to have his physical, mental, and moral integrity respected.

2. No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person.

27. Article 33 of the Convention provides for the establishment of the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. As stated in its regulations, the Commission's principal function is to promote the observance and defence of human rights and to serve as an advisory body to the Organization of American States in this area.<sup>26</sup> In fulfilling this function, the Commission has looked to the Inter-American Convention to Prevent and Punish Torture to guide its interpretation of what is meant by torture under article 5.<sup>27</sup> The Inter-American Convention to Prevent and Punish Torture was adopted by the Organization of American States on 9 December 1985 and entered into force on 28 February 1987.<sup>28</sup> Article 2 of the Convention defines torture as:

...stany act intentionally performed whereby physical or mental pain or suffering is inflicted on a person for purposes of criminal investigation, as a means of intimidation, as personal punishment, as a preventive measure, as a penalty, or for any other purpose. Torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.

28. Under article 1, the States parties to the Convention undertake to prevent and punish torture in accordance with the terms of the Convention. States parties to the Convention are required to conduct an immediate and proper investigation into any allegation that torture has occurred within their jurisdiction.

29. Article 8 provides that "States Parties shall guarantee that any person making an accusation of having been subjected to torture within their jurisdiction shall have the right to an impartial examination of his case". Likewise, if there is an accusation or well-grounded reason to believe that an act of torture has been committed within their jurisdiction, the States parties must guarantee that their respective authorities will proceed properly and immediately to conduct an investigation into the case and initiate, whenever appropriate, the corresponding criminal process.

30. In one of its 1998 country reports, the Commission noted that an obstacle to the effective prosecution of torturers is the lack of independence in an investigation of claims of torture, as the investigation is required to be undertaken by federal bodies likely to be acquainted with

<sup>25</sup> Organization of American States, *Treaty Series*, No. 36, and United Nations, *Treaty Series*, vol. 1144, p. 123, reprinted in "Basic documents pertaining to human rights in the inter-American system" (OEA/Ser. L.V/II.82, document 6, rev. 1), p. 25 (1992).

<sup>26</sup> "Regulations of the Inter-American Commission on Human Rights" (OEA/Ser.L.V/II.92), document 31, rev. 3 of 3 May 1996, art. (1).

<sup>27</sup> See case 10.832, report No. 35/96, Inter-American Commission on Human Rights Annual Report 1997, para. 75.

<sup>28</sup> Organization of American States, *Treaty Series*, No. 67.



parties accused of committing torture.<sup>29</sup> The Commission cited article 8 to underscore the importance of an “impartial examination” of each case.<sup>30</sup>

31. The Inter-American Court of Human Rights has addressed the necessity of investigating claims of violations of the American Convention on Human Rights. In its decision in the Velásquez Rodríguez case, judgement of 29 July 1988, the Court stated that:

The State is obligated to investigate every situation involving a violation of the rights protected by the Convention. If the State apparatus acts in such a way that the violation goes unpunished and the victim's full enjoyment of such rights is not restored as soon as possible, the State has failed to comply with its duty to ensure the free and full exercise of those rights to the persons within its jurisdiction.

32. Article 5 of the Convention provides for the right to be free from torture. Although the case dealt specifically with the issue of disappearance, one of the rights referred to by the Court as guaranteed by the American Convention on Human Rights is the right not to be subjected to torture or other forms of ill-treatment.

## 2. The European Court of Human Rights

33. On 4 November 1950, the Council of Europe adopted the European Convention for the Protection of Human Rights and Fundamental Freedoms, which entered into force on 3 September 1953.<sup>31</sup> Article 3 of the European Convention states that “No one shall be subjected to torture or to inhuman or degrading treatment or punishment”. The European Convention established control mechanisms consisting of the European Court and the European Commission of Human Rights. Since the reform that entered into force on 1 November 1998, a new permanent Court has replaced the former Court and Commission. The right of individual applications is now mandatory, and all victims have direct access to the Court. The Court has had the occasion to consider the necessity of investigating allegations of torture as a way of ensuring the rights guaranteed by article 3.

34. The first judgement on this issue was the decision in the *Aksoy v. Turkey* case (100/1995/606/694), delivered on 18 December 1996.<sup>32</sup> In that case, the Court considered that:

[w]here an individual is taken into police custody in good health but is found to be injured at the time of release, it is incumbent on the State to provide a plausible explanation as to the causing of the injury, failing which a clear issue arises under Article 3 of the Convention.<sup>33</sup>

35. The Court went on to hold that the injuries inflicted on the applicant resulted from torture and that article 3 had been violated.<sup>34</sup> Furthermore, the Court interpreted article 13 of the Convention, which provides

for the right to an effective remedy before a national authority, as imposing an obligation to investigate claims of torture thoroughly. Considering the “fundamental importance of the prohibition of torture” and the vulnerability of torture victims, the Court held that “Article 13 imposes, without prejudice to any other remedy available under the domestic system, an obligation on States to carry out a thorough and effective investigation of incidents of torture”.<sup>35</sup>

36. According to the Court's interpretation, the notion of an “effective remedy” in article 13 entails a thorough investigation of every “arguable claim” of torture. The Court noted that although the Convention has no express provision, such as article 12 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, “such a requirement is implicit in the notion of an ‘effective remedy’ under Article 13”.<sup>36</sup> The Court then found that the State had violated article 13 by failing to investigate the applicant's allegation of torture.<sup>37</sup>

37. In a judgement of 28 October 1998 in the case of *Assenov and Others v. Bulgaria* (90/1997/874/1086), the Court went even further in recognizing an obligation for the State to investigate allegations of torture not only under article 13 but also under article 3. In this case, a young Romany arrested by the police showed medical evidence of beatings, but it was impossible to assess, on the basis of available evidence, whether these injuries were caused by his father or by the police. The Court recognized that “the degree of bruising found by the doctor who examined Mr. Assenov ... indicates that the latter's injuries, whether caused by his father or by the police, were sufficiently serious to amount to ill-treatment within the scope of Article 3”.<sup>38</sup> Contrary to the Commission that held that there was no violation of article 3, the Court did not stop there. It went on and considered that the facts raised “a reasonable suspicion that these injuries may have been caused by the police”.<sup>39</sup> Hence the Court held that:

[I]n these circumstances, where an individual raises an arguable claim that he has been seriously ill-treated by the police or other such agents of the State unlawfully and in breach of Article 3, that provision, read in conjunction with the State's general duty under Article 1 of the Convention “to secure to everyone within their jurisdiction the rights and freedoms defined in [the] Convention”, requires by implication that there should be an effective official investigation. This investigation... should be capable of leading to the identification and punishment of those responsible. If this were not the case, the general legal prohibition of torture and inhuman and degrading treatment and punishment, despite its fundamental importance..., would be ineffective in practice and it would be possible in some cases for agents of the State to abuse the rights of those within their control with virtual impunity.<sup>40</sup>

38. For the first time, the Court concluded that a violation of article 3 had occurred, not from ill-treatment per se but from a failure to carry out effective official investigation on the allegation of ill-treatment. In addition,

<sup>29</sup> Inter-American Commission on Human Rights, *Report on the Situation of Human Rights in Mexico*, 1998, para. 323.

<sup>30</sup> *Ibid.*, para. 324.

<sup>31</sup> United Nations, *Treaty Series*, vol. 213, p. 222.

<sup>32</sup> See Additional Protocols Nos. 3, 5 and 8, which entered into force on 21 September 1970, 20 December 1971 and 1 January 1990, *European Treaty Series* Nos. 45, 46 and 118, respectively.

<sup>33</sup> See European Court of Human Rights, *Reports of Judgments and Decisions* 1996–VI, para. 61.

<sup>34</sup> *Ibid.*, para. 64.

<sup>35</sup> *Ibid.*, para. 98.

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*, para. 100.

<sup>38</sup> *Ibid.*, *Reports of Judgments and Decisions* 1998–VIII, para. 95.

<sup>39</sup> *Ibid.*, para. 101.

<sup>40</sup> *Ibid.*, para. 102.

tion, the Court reiterated its position in the Aksoy case and concluded that there had also been a violation of article 13. The Court considered that:

Where an individual has an arguable claim that he has been ill-treated in breach of Article 3, the notion of an effective remedy entails, in addition to a thorough and effective investigation of the kind as also required by Article 3 . . . , effective access for the complainant to the investigatory procedure and payment of compensation where appropriate.<sup>41</sup>

### 3. *The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*

39. In 1987, the Council of Europe adopted the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which entered into force on 1 February 1989.<sup>42</sup> By 1 March 1999, all 40 member States of the Council of Europe had ratified the Convention. This Convention complements the judicial mechanism of the European Convention on Human Rights with a preventive mechanism. The Convention intentionally does not create substantive norms. The Convention established the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, consisting of one member per member State. The members elected to the Committee should be of high moral standard, impartial, independent and also available to carry out field missions.

40. The Committee carries out visits to member States of the Council of Europe, partially on a regular periodic basis and partially on an ad hoc basis. A visiting delegation of the Committee consists of members of the Committee, accompanying experts in the medical, legal or other fields, interpreters and members of the secretariat. These delegations visit persons deprived of their liberty by the authorities of the country visited.<sup>43</sup> The powers of each visiting delegation are quite vast: it may visit any place where persons are held deprived of their liberty; make unannounced visits to any such place; repeat visits to these places; talk to persons deprived of their liberty in private; visit any or all persons it chooses to in these places; and see all premises (not only cell areas) without restrictions. The delegation can have access to all papers and files concerning the persons visited. The entire work of the Committee is based on confidentiality and cooperation.

41. After a visit, the Committee writes a report. Based on the facts observed during the visit, the report comments on the conditions found, makes concrete recommendations and asks any questions that need further clarification. The State party answers the report in writing and thereby establishes a dialogue between the Committee and the State party, which continues until the following visit. The Committee's reports and the State party's answers are confidential documents, but the State party

(not the Committee) may decide to publish both the reports and the answers. So far, nearly all the States parties have made public both reports and answers.

42. In the course of its activities over the past 10 years, the Committee has gradually developed a set of criteria for the treatment of persons held in custody that constitutes general standards. These standards deal not only with the material conditions but also with procedural safeguards. For example, three safeguards advocated by the Committee for persons held in police custody are:

(a) The right of a person deprived of liberty, if he or she so desires, to inform immediately a third party (family member) of the arrest;

(b) The right of a person deprived of liberty to have immediate access to a lawyer;

(c) The right of a person deprived of liberty to have access to a physician, including, if he or she so wishes, a physician of his or her own choice.

43. Furthermore, the Committee has stressed repeatedly that one of the most effective means of preventing ill-treatment by law enforcement officials lies in the diligent examination by competent authorities of all complaints of such treatment brought before them and, where appropriate, the imposition of a suitable penalty. This has a strong dissuasive effect.

### 4. *The African Commission on Human and Peoples' Rights and the African Court on Human and Peoples' Rights*

44. In comparison with the European and inter-American systems, Africa does not have a convention on torture and its prevention. The question of torture is examined on the same level as are other human rights violations. The question of torture is dealt with primarily in the African Charter of Human and Peoples' Rights, which was adopted by the Organization of African Unity on 27 June 1981 and which entered into force on 21 October 1986.<sup>44</sup> Article 5 of the African Charter states:

Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

45. In accordance with article 30 of the African Charter, the African Commission on Human and Peoples' Rights was established in June 1987 and was charged "to promote human and peoples' rights and ensure their protection in Africa". In its periodic sessions, the Commission has passed several country resolutions on matters concerning human rights in Africa, some of which have dealt with torture, among other violations. In some of its country resolutions, the Commission raised concerns about the degradation of human rights situations, including the practice of torture.

<sup>41</sup> Ibid., para. 117.

<sup>42</sup> *European Treaty Series*, No. 126.

<sup>43</sup> A person deprived of liberty is any person deprived of liberty by a public authority, such as, but not exclusively, persons arrested or in any form of detention, prisoners awaiting trial, sentenced prisoners and persons involuntarily confined to psychiatric hospitals.

<sup>44</sup> Organization of African Unity, document CAB/LEG/67/3, Rev. 5, 21, *International Legal Materials*, 58 (1982).

46. The Commission has established new mechanisms, such as the Special Rapporteur on Prisons, the Special Rapporteur on Arbitrary and Summary Executions and the Special Rapporteur on Women, whose mandate is to report during the open sessions of the Commission. These mechanisms have created opportunities for victims and NGOs to send information directly to special rapporteurs. At the same time, a victim or an NGO can make a complaint to the Commission regarding acts of torture as defined in article 5 of the African Charter. While an individual complaint is pending before the Commission, the victim or the NGO can send the same information to special rapporteurs for their public reports to the Commission's sessions. To provide a forum for adjudicating claims of violations of the rights guaranteed in the African Charter, the Organization of African Unity Assembly adopted a protocol for the establishment of the African Court of Human and Peoples' Rights in June 1998.

#### **D. The International Criminal Court**

47. The Rome Statute of the International Criminal Court, adopted on 17 July 1998, established a permanent international criminal court to try individuals responsible for genocide, crimes against humanity and war crimes (A/CONF.183/9). The Court has jurisdiction over cases alleging torture either as part of the crime of genocide or as a crime against humanity, if the torture is committed as part of a widespread or systematic attack, or as a war crime under the Geneva Conventions of 1949. Torture is defined in the Rome Statute as the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control of the accused. As of 25 September 2000, the Rome Statute of the International Criminal Court had been signed by 113 countries and ratified by 21 States. The Court will have its headquarters in The Hague. This Court has jurisdiction only in cases in which States are unable or unwilling to prosecute individuals responsible for the crimes described in the Rome Statute.

## CHAPTER II

## RELEVANT ETHICAL CODES

48. All professions work within ethical codes, which provide a statement of the shared values and acknowledged duties of professionals and set moral standards with which they are expected to comply. Ethical standards are established primarily in two ways: by international instruments drawn up by bodies like the United Nations and by codes of principles drafted by the professions themselves, through their representative associations, nationally or internationally. The fundamental tenets are invariably the same and focus on obligations owed by the professional to individual clients or patients, to society at large and to colleagues in order to maintain the honour of the profession. These obligations reflect and complement the rights to which all people are entitled under international instruments.

**A. Ethics of the legal profession**

49. As the ultimate arbiters of justice, judges play a special role in the protection of the rights of citizens. International standards create an ethical duty on the part of judges to ensure that the rights of individuals are protected. Principle 6 of the United Nations Basic Principles on the Independence of the Judiciary states that "The principle of the independence of the judiciary entitles and requires the judiciary to ensure that judicial proceedings are conducted fairly and that the rights of the parties are respected".<sup>45</sup> Similarly, prosecutors have an ethical duty to investigate and prosecute a crime of torture committed by public officials. Article 15 of the United Nations Guidelines on the Role of Prosecutors states: "Prosecutors shall give due attention to the prosecution of crimes committed by public officials, particularly corruption, abuse of power, grave violations of human rights and other crimes recognized by international law and, where authorized by law or consistent with local practice, the investigation of such offences."<sup>46</sup>

50. International standards also establish a duty for lawyers, in carrying out their professional functions, to promote and protect human rights and fundamental

freedoms. Principle 14 of the United Nations Basic Principles on the Role of Lawyers provides: "Lawyers, in protecting the rights of their clients and in promoting the cause of justice, shall seek to uphold human rights and fundamental freedoms recognized by national and international law and shall at all times act freely and diligently in accordance with the law and recognized standards and ethics of the legal profession."<sup>47</sup>

**B. Health-care ethics**

51. There are very clear links between concepts of human rights and the well-established principle of health-care ethics. The ethical obligations of health professionals are articulated at three levels and are reflected in United Nations documents in the same way as they are for the legal profession. They are also embodied in statements issued by international organizations representing health professionals, such as the World Medical Association, the World Psychiatric Association and the International Council of Nurses.<sup>48</sup> National medical associations and nursing organizations also issue codes of ethics, which their members are expected to follow. The central tenet of all health-care ethics, however articulated, is the fundamental duty always to act in the best interests of the patient, regardless of other constraints, pressures or contractual obligations. In some countries, medical ethical principles, such as that of doctor-patient confidentiality, are incorporated into national law. Even where ethical principles are not established in law in this way, all health professionals are morally bound by the standards set by their professional bodies. They are judged to be guilty of misconduct if they deviate from professional standards without reasonable justification.

*1. United Nations statements relevant to health professionals*

52. Health professionals, like all other persons working in prison systems, must observe the Standard Minimum Rules for the Treatment of Prisoners, which require that medical, including psychiatric, services must be

<sup>45</sup> Adopted by the Seventh United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Milan, Italy, from 26 August to 6 September 1985 and endorsed by General Assembly resolutions 40/32 of 29 November 1985 and 40/146 of 13 December 1985.

<sup>46</sup> Adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Havana from 27 August to 7 September 1990.

<sup>47</sup> See footnote 46 above.

<sup>48</sup> There are also a number of regional groupings, such as the Commonwealth Medical Association and the International Conference of Islamic Medical Associations that issue important statements on medical ethics and human rights for their members.

available to all prisoners without discrimination and that all sick prisoners or those requesting treatment be seen daily.<sup>49</sup> These requirements reinforce the ethical obligations of physicians, discussed below, to treat and act in the best interests of patients for whom they have a duty to care. In addition, the United Nations has specifically addressed the ethical obligations of doctors and other health professionals in the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.<sup>50</sup> These make clear that health professionals have a moral duty to protect the physical and mental health of detainees. They are specifically prohibited from using medical knowledge and skills in any manner that contravenes international statements of individual rights.<sup>51</sup> In particular, it is a gross contravention of health-care ethics to participate, actively or passively, in torture or condone it in any way.

53. "Participation in torture" includes evaluating an individual's capacity to withstand ill-treatment; being present at, supervising or inflicting maltreatment; resuscitating individuals for the purposes of further maltreatment or providing medical treatment immediately before, during or after torture on the instructions of those likely to be responsible for it; providing professional knowledge or individuals' personal health information to torturers; and intentionally neglecting evidence and falsifying reports, such as autopsy reports and death certificates.<sup>52</sup> The United Nations Principles also incorporate one of the fundamental rules of health-care ethics by emphasizing that the only ethical relationship between prisoners and health professionals is one designed to evaluate, protect and improve prisoners' health. Thus, assessment of detainees' health in order to facilitate punishment or torture is clearly unethical.

## 2. *Statements from international professional bodies*

54. Many statements from international professional bodies focus on principles relevant to the protection of human rights and represent a clear international medical consensus on these issues. Declarations of the World Medical Association define internationally agreed aspects of the ethical duties to which all doctors are held. The World Medical Association's Declaration of Tokyo<sup>53</sup> reiterates the prohibition of any form of medical participation or medical presence in torture or ill-treatment. This is reinforced by the United Nations Principles that specifically refer to the Declaration of Tokyo. Doctors are

<sup>49</sup> Standard Minimum Rules for the Treatment of Prisoners and Procedures for the Effective Implementation of the Standard Minimum Rules, adopted by the United Nations in 1955.

<sup>50</sup> Adopted by the General Assembly in 1982.

<sup>51</sup> Particularly the Universal Declaration of Human Rights, the International Covenants on Human Rights and the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

<sup>52</sup> Health professionals must, however, bear in mind the duty of confidentiality owed to patients and the obligation to obtain informed consent for disclosure of information, particularly when individuals may be put at risk by such disclosure (see chapter II, sect. C.3).

<sup>53</sup> Adopted by the World Medical Association in 1975.

clearly prohibited from providing information or any medical instrument or substance that would facilitate ill-treatment. The same rule is specifically applied to psychiatry in the World Psychiatric Association's Declaration of Hawaii,<sup>54</sup> which prohibits the misuse of psychiatric skills to violate the human rights of any individual or group. The International Conference on Islamic Medicine made a similar point in its Declaration of Kuwait,<sup>55</sup> which bans doctors from allowing their special knowledge to be used "to harm, destroy or inflict damage on the body, mind or spirit, whatever the military or political reason". Similar provisions are made for nurses in the directive on the Nurse's Role in the Care of Detainees and Prisoners.<sup>56</sup>

55. Health professionals also have a duty to support colleagues who speak out against human rights violations. Failure to do so risks not only an infringement of patient rights and a contravention of the declarations listed above but also brings the health professions into disrepute. Tarnishing the honour of the profession is considered to be serious professional misconduct. The World Medical Association's resolution on human rights<sup>57</sup> calls on all national medical associations to review the human rights situation in their own countries and ensure that doctors do not conceal evidence of abuse even where they fear reprisal. It requires national bodies to provide clear guidance, especially for doctors working in the prison system, to protest alleged violations of human rights and provide effective machinery for investigating doctors' unethical activities in the human rights sphere. It also requires that they support individual doctors who call attention to human rights abuses. The World Medical Association's subsequent Declaration of Hamburg<sup>58</sup> reaffirms the responsibility of individuals and organized medical groups worldwide to encourage doctors to resist torture or any pressure to act contrary to ethical principles. It calls upon individual doctors to speak out against maltreatment and urges national and international medical organizations to support doctors who resist such pressure.

## 3. *National codes of medical ethics*

56. The third level at which ethical principles are articulated is through national codes. These reflect the same core values as mentioned above, since medical ethics are the expression of values common to all doctors. In virtually all cultures and codes, the same basic presumptions occur about duties to avoid harm, help the sick, protect the vulnerable and not discriminate between patients on any basis other than the urgency of their medical needs. Identical values are present in the codes for the nursing profession. A problematic aspect of ethical principles is that they do not, however, provide definitive rules for every dilemma but require some interpretation. When weighing ethical dilemmas, it is vital that health professionals bear in mind the fundamental moral

<sup>54</sup> Adopted in 1977.

<sup>55</sup> Adopted in 1981 (1401 in the Islamic calendar).

<sup>56</sup> Adopted by the International Council of Nurses in 1975.

<sup>57</sup> Adopted in 1990.

<sup>58</sup> Adopted in 1997.

obligations expressed in their shared professional values but also that they implement them in a manner that reflects the basic duty to avoid harm to their patients.

### C. Principles common to all codes of health-care ethics

57. The principle of professional independence requires health professionals always to concentrate on the core purpose of medicine, which is to alleviate suffering and distress and avoid harm, despite other pressures. Several other ethical principles are so fundamental that they are invariably found in all codes and ethical statements. The most basic are the injunctions to provide compassionate care, do no harm and to respect patients' rights. These are central requirements for all health professionals.

#### 1. *The duty to provide compassionate care*

58. The duty to provide care is expressed in a variety of ways in national and international codes and declarations. One aspect of this duty is the medical duty to respond to those in medical need. This is reflected in the World Medical Association's International Code of Medical Ethics,<sup>59</sup> which recognizes the moral obligation of doctors to provide emergency care as a humanitarian duty. The duty to respond to need and suffering is echoed in traditional statements in virtually all cultures.

59. Underpinning much of modern medical ethics are the principles established in the earliest statements of professional values that require doctors to provide care even at some risk to themselves. For example, the Caraka Samhita, a Hindu code dating from the first century AD, instructs doctors to "endeavour for the relief of patients with all thy heart and soul. Thou shall not desert or injure thy patient for the sake of thy life or thy living". Similar instructions were given in early Islamic codes and the modern Declaration of Kuwait requires doctors to focus on the needy, be they "near or far, virtuous or sinner, friend or enemy".

60. Western medical values have been dominated by the influence of the Hippocratic oath and similar pledges, such as the Prayer of Maimonides. The Hippocratic oath represents a solemn promise of solidarity with other doctors and a commitment to benefit and care for patients while avoiding harming them. It also contains a promise to maintain confidentiality. These four concepts are reflected in various forms in all modern professional codes of health-care ethics. The World Medical Association's Declaration of Geneva<sup>60</sup> is a modern restatement of the Hippocratic values. It is a promise by which doctors undertake to make the health of their patients their primary consideration and vow to devote themselves to the service of humanity with conscience and dignity.

61. Aspects of the duty to care are reflected in many of the World Medical Association's declarations, which make clear that doctors must always do what is best for

the patient, including detainees and alleged criminals. This duty is often expressed through the notion of professional independence, requiring doctors to adhere to best medical practices despite any pressure that might be applied. The World Medical Association's International Code of Medical Ethics emphasizes doctors' duty to provide care "in full technical and moral independence, with compassion and respect for human dignity". It also stresses the duty to act only in the patient's interest and says that doctors owe their patients complete loyalty. The World Medical Association's Tokyo Declaration and Declaration on Physician Independence and Professional Freedom<sup>61</sup> make unambiguously clear that doctors must insist on being free to act in patients' interests, regardless of other considerations, including the instructions of employers, prison authorities or security forces. The latter declaration requires doctors to ensure that they "have the professional independence to represent and defend the health needs of patients against all who would deny or restrict needed care for those who are sick or injured". Similar principles are prescribed for nurses in the International Council of Nurses Code of Ethics.

62. Another way in which duty to provide care is expressed by the World Medical Association is through its recognition of patient rights. Its Declaration of Lisbon on the Rights of the Patient<sup>62</sup> recognizes that every person is entitled, without discrimination, to appropriate health care and reiterates that doctors must always act in a patient's best interest. Patients must be guaranteed autonomy and justice, according to the Declaration, and both doctors and providers of medical care must uphold patient's rights. "Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them." Individuals are entitled to appropriate health care, regardless of factors such as their ethnic origin, political beliefs, nationality, gender, religion or individual merit. People accused or convicted of crimes have an equal moral entitlement to appropriate medical and nursing care. The World Medical Association's Declaration of Lisbon emphasizes that the only acceptable criterion for discriminating between patients is the relative urgency of their medical need.

#### 2. *Informed consent*

63. While the declarations reflecting a duty of care all emphasize an obligation to act in the best interests of the individual being examined or treated, this presupposes that health professionals know what is in the patient's best interest. An absolutely fundamental precept of modern medical ethics is that patients themselves are the best judge of their own interests. This requires health professionals to give normal precedence to a competent adult patient's wishes rather than to the views of any person in authority about what would be best for that individual. Where the patient is unconscious or otherwise incapable of giving valid consent, health professionals must make a judgement about how that person's best interests can be

<sup>59</sup> Adopted in 1949.

<sup>60</sup> Adopted in 1948.

<sup>61</sup> Adopted by the World Medical Association in 1986.

<sup>62</sup> Adopted by the World Medical Association in 1981; amended by its General Assembly at its forty-seventh session in September 1995.

protected and promoted. Nurses and doctors are expected to act as an advocate for their patients, and this is made clear in statements such as the World Medical Association's Declaration of Lisbon and the International Council of Nurses' statement on the Nurse's Role in Safeguarding Human Rights.<sup>63</sup>

64. The World Medical Association's Declaration of Lisbon specifies the duty for doctors to obtain voluntary and informed consent from mentally competent patients to any examination or procedure. This means that individuals need to know the implications of agreeing and the consequences of refusing. Before examining patients, health professionals must, therefore, explain frankly the purpose of the examination and treatment. Consent obtained under duress or as a result of false information being given to the patient is invalid, and doctors acting on it are likely to be in breach of medical ethics. The graver the implications of the procedure for the patient, the greater the moral imperative to obtain properly informed consent. That is to say, where examination and treatment are clearly of therapeutic benefit to individuals, their implied consent by cooperating in the procedures may be sufficient. In cases where examination is not primarily for the purposes of providing therapeutic care, great caution is required in ensuring that the patient knows and agrees to this and that it is in no way contrary to the individual's best interests. As previously stated, examination to ascertain whether an individual can withstand punishment, torture or physical pressure during interrogation is unethical and contrary to the purpose of medicine. The only ethical assessment of a prisoner's health is one designed to evaluate the patient's health in order to maintain and improve optimum health, not to facilitate punishment. Physical examination for evidential purposes in an inquiry requires consent that is informed in the sense that the patient understands factors such as how the health data gained from the examination will be used, how they will be stored and who will have access to them. If these and other points relevant to the patient's decision are not made clear in advance, consent to examination and recording of information is invalid.

### 3. Confidentiality

65. All ethical codes, from the Hippocratic oath to modern times, include the duty of confidentiality as a fundamental principle, which also features prominently in the World Medical Association's declarations, such as the Declaration of Lisbon. In some jurisdictions, the obligation of professional secrecy is seen as so important that it is incorporated into national law. The duty of confidentiality is not absolute and may be ethically breached in exceptional circumstances where failure to do so will foreseeably give rise to serious harm to people or a serious perversion of justice. Generally, however, the duty of confidentiality covering identifiable personal health information can be overridden only with the informed permission of the patient.<sup>64</sup> Non-identifiable patient information can be freely used for other purposes and

should be used preferably in all situations where disclosure of the patient's identity is non-essential. This may be the case, for example, in the collection of data about patterns of torture or maltreatment. Dilemmas arise where health professionals are pressured or required by law to disclose identifiable information which would be likely to put patients at risk of harm. In such cases, the fundamental ethical obligations are to respect the autonomy and best interests of the patient, to do good and avoid harm. This supersedes other considerations. Doctors should make clear to the court or the authority requesting information that they are bound by professional duties of confidentiality. Health professionals responding in this way are entitled to the support of their professional association and colleagues. In addition, during periods of armed conflict, international humanitarian law gives specific protection to doctor-patient confidentiality, requiring that doctors do not denounce people who are sick or wounded.<sup>65</sup> Health professionals are protected in that they cannot be compelled to disclose information about their patients in such situations.

### D. Health professionals with dual obligations

66. Health professionals have dual obligations, in that they owe a primary duty to the patient to promote that person's best interests and a general duty to society to ensure that justice is done and violations of human rights prevented. Dilemmas arising from these dual obligations are particularly acute for health professionals working with the police, military, other security services or in the prison system. The interests of their employer and their non-medical colleagues may be in conflict with the best interests of the detainee patients. Whatever the circumstances of their employment, all health professionals owe a fundamental duty to care for the people they are asked to examine or treat. They cannot be obliged by contractual or other considerations to compromise their professional independence. They must make an unbiased assessment of the patient's health interests and act accordingly.

#### 1. Principles guiding all doctors with dual obligations

67. In all cases where doctors are acting for another party, they have an obligation to ensure that this is understood by the patient.<sup>66</sup> Doctors must identify themselves to patients and explain the purpose of any examination or treatment. Even when doctors are appointed and paid by a third party, they retain a clear duty of care to any patient whom they examine or treat. They must refuse to comply with any procedures that may harm patients or leave them physically or psychologically vulnerable to harm. They must ensure that their contractual terms allow them professional independence to make clinical judgements. Doctors must ensure that any person in custody has access to any medical examination and treatment needed. Where the detainee is a minor or a vulnerable adult, doctors have additional duties to act as an advocate. Doctors retain a

<sup>63</sup> Adopted in 1983.

<sup>64</sup> Except for common public health requirements, such as the reporting by name of individuals with infectious diseases, drug addiction, mental disorders, etc.

<sup>65</sup> Article 16 of Protocol I (1977) and article 10 of Protocol II (1977), additional to the Geneva Conventions of 1949.

<sup>66</sup> These principles are extracted from *Doctors with Dual Obligations* (London, British Medical Association, 1995).

general duty of confidentiality so that information should not be disclosed without the patient's knowledge. They must ensure that their medical records are kept confidential. Doctors have a duty to monitor and speak out when services in which they are involved are unethical, abusive, inadequate or pose a potential threat to patients' health. In such cases, they have an ethical duty to take prompt action as failure to take an immediate stand makes protest at a later stage more difficult. They should report the matter to appropriate authorities or international agencies who can investigate, but without exposing patients, their families or themselves to foreseeable serious risk of harm. Doctors and professional associations should support colleagues who take such action on the basis of reasonable evidence.

## 2. *Dilemmas arising from dual obligations*

68. Dilemmas may occur when ethics and law are in contradiction. Circumstances can arise where their ethical duties oblige health professionals not to obey a particular law, such as a legal obligation to reveal confidential medical information about a patient. There is consensus in international and national declarations of ethical precepts that other imperatives, including the law, cannot oblige health professionals to act contrary to medical ethics and to their conscience. In such cases, health professionals must decline to comply with the law or a regulation rather than compromise basic ethical precepts or expose patients to serious danger.

69. In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaching the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters.

70. The ethical obligations of a doctor may vary according to the context of the doctor-patient encounter and the possibility of the patient being able to exercise free choice about the disclosure decision. For example, where the doctor and patient are in a clearly therapeutic situation, such as the provision of care in hospital, there is a strong moral imperative for doctors to preserve the usual rules of confidentiality that normally prevail in therapeutic relationships. Reporting evidence of torture obtained in such encounters is entirely appropriate as long as the patient does not forbid it. Doctors should report such

evidence if patients request it or give properly informed consent to it. They should support patients in such decisions.

71. Forensic doctors have a different relationship with the individuals they examine and usually have an obligation to report their observations factually. The patient has less power and choice in such situations and may not be able to speak openly about what has occurred. Before beginning any examination, forensic doctors must explain their role to the patient and make clear that medical confidentiality is not a usual part of their role, as it would be in a therapeutic context. Regulations may not permit the patient to refuse examination, but the patient has an option of choosing whether to disclose the cause of any injury. Forensic doctors should not falsify their reports but should provide impartial evidence, including making clear in their reports any evidence of maltreatment.<sup>67</sup>

72. Prison doctors are primarily providers of therapeutic treatment but they also have the task of examining detainees arriving in prison from police custody. In this role or in treatment of people within a prison, they may discover evidence of unacceptable violence, which prisoners themselves are not in a realistic position to denounce. In such situations, doctors must bear in mind the best interests of the patient and their duties of confidentiality to that person, but the moral arguments for the doctor to denounce evident maltreatment are strong, since prisoners themselves are often unable to do so effectively. Where prisoners agree to disclosure, no conflict arises and the moral obligation is clear. If a prisoner refuses to allow disclosure, doctors must weigh the risk and potential danger to that individual patient against the benefits to the general prison population and the interests of society in preventing the perpetuation of abuse.

73. Health professionals must also bear in mind that reporting abuse to the authorities in whose jurisdiction it is alleged to have occurred may well entail risks of harm for the patient or for others, including the whistle-blower. Doctors must not knowingly place individuals in danger of reprisal. They are not exempt from taking action but should use discretion and must consider reporting the information to a responsible body outside the immediate jurisdiction or, where this would not entail foreseeable risks to health professionals and patients, report it in a non-identifiable manner. Clearly, if the latter solution is taken, health professionals must take into account the likelihood of pressure being brought on them to disclose identifying data or the possibility of having their medical records forcibly seized. While there are no easy solutions, health professionals should be guided by the basic injunction to avoid harm above all other considerations and seek advice, where possible, from national or international medical bodies.

<sup>67</sup> See V. Iacopino and others, "Physician complicity in misrepresentation and omission of evidence of torture in postdetention medical examinations in Turkey", *Journal of the American Medical Association (JAMA)*, vol. 276 (1996), pp. 396-402.



## CHAPTER III

## LEGAL INVESTIGATION OF TORTURE

74. States are required under international law to investigate reported incidents of torture promptly and impartially. Where evidence warrants it, a State in whose territory a person alleged to have committed or participated in torture is present, must either extradite the alleged perpetrator to another State that has competent jurisdiction or submit the case to its own competent authorities for the purpose of prosecution under national or local criminal laws. The fundamental principles of any viable investigation into incidents of torture are competence, impartiality, independence, promptness and thoroughness. These elements can be adapted to any legal system and should guide all investigations of alleged torture.

75. Where investigative procedures are inadequate because of a lack of resources or expertise, the appearance of bias, the apparent existence of a pattern of abuse or other substantial reasons, States shall pursue investigations through an independent commission of inquiry or similar procedure. Members of that commission must be chosen for their recognized impartiality, competence and independence as individuals. In particular, they must be independent of any institution, agency or person that may be the subject of the inquiry.

76. Section A describes the broad purpose of an investigation into torture. Section B sets forth basic principles on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. Section C sets forth suggested procedures for conducting an investigation into alleged torture, first considering the decision regarding the appropriate investigative authority, then offering guidelines regarding collection of oral testimony from the reported victim and other witnesses and collection of physical evidence. Section D provides guidelines for establishing a special independent commission of inquiry. These guidelines are based on the experiences of several countries that have established independent commissions to investigate alleged human rights abuses, including extrajudicial killings, torture and disappearances.

#### A. Purposes of an investigation into torture

77. The broad purpose of the investigation is to establish the facts relating to alleged incidents of torture, with a view to identifying those responsible for the incidents and facilitating their prosecution, or for use in the context of other procedures designed to obtain redress for victims. The issues addressed here may also be relevant

for other types of investigations of torture. To fulfil this purpose, those carrying out the investigation must, at a minimum, seek to obtain statements from the victims of alleged torture; to recover and preserve evidence, including medical evidence, related to the alleged torture to aid in any potential prosecution of those responsible; to identify possible witnesses and obtain statements from them concerning the alleged torture; and to determine how, when and where the alleged incidents of torture occurred as well as any pattern or practice that may have brought about the torture.

#### B. Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

78. The following principles represent a consensus among individuals and organizations having expertise in the investigation of torture. The purposes of effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (hereinafter referred to as torture or other ill-treatment) include the following:

(a) Clarification of the facts and establishment and acknowledgement of individual and State responsibility for victims and their families;

(b) Identification of measures needed to prevent recurrence;

(c) Facilitation of prosecution or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible and demonstration of the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.

79. States must ensure that complaints and reports of torture or ill-treatment are promptly and effectively investigated. Even in the absence of an express complaint, an investigation should be undertaken if there are other indications that torture or ill-treatment might have occurred. The investigators, who shall be independent of the suspected perpetrators and the agency they serve, must be competent and impartial. They must have access to or be empowered to commission investigations by impartial medical or other experts. The methods used to carry out these investigations must meet the highest professional standards, and the findings must be made public.

80. The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry.<sup>68</sup> The persons conducting the investigation must have at their disposal all the necessary budgetary and technical resources for effective investigation. They must also have the authority to oblige all those acting in an official capacity allegedly involved in torture or ill-treatment to appear and testify. The same applies to any witness. To this end, the investigative authority is entitled to issue summonses to witnesses, including any officials allegedly involved, and to demand the production of evidence. Alleged victims of torture or ill-treatment, witnesses, those conducting the investigation and their families must be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture or ill-treatment should be removed from any position of control or power, whether direct or indirect, over complainants, witnesses or their families, as well as those conducting the investigation.

81. Alleged victims of torture or ill-treatment and their legal representatives must be informed of, and have access to, any hearing as well as to all information relevant to the investigation and must be entitled to present other evidence.

82. In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse, or for other substantial reasons, States must ensure that investigations are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission should be chosen for their recognized impartiality, competence and independence as individuals. In particular, they must be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission must have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these principles.<sup>69</sup> A written report, made within a reasonable time, must include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. On completion, this report must be made public. It must also describe in detail specific events that were found to have occurred, the evidence upon which such findings were based and list the names of witnesses who testified with the exception of those whose identities have been withheld for their own protection. The State must, within a reasonable period of time, reply to the report of the investigation and, as appropriate, indicate steps to be taken in response.

83. Medical experts involved in the investigation of torture or ill-treatment should behave at all times in conformity with the highest ethical standards and, in particular, must obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations must be conducted in private under the control of

the medical expert and outside the presence of security agents and other government officials. The medical expert should promptly prepare an accurate written report. This report should include at least the following:

(a) The circumstances of the interview. The name of the subject and name and affiliation of those present at the examination; the exact time and date, location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g. detention centre, clinic, house, etc.); any appropriate circumstances at the time of the examination (e.g. nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner, threatening statements to the examiner, etc.); and any other relevant factor;

(b) The background. A detailed record of the subject's story as given during the interview, including alleged methods of torture or ill-treatment, the time when torture or ill-treatment was alleged to have occurred and all complaints of physical and psychological symptoms;

(c) A physical and psychological examination. A record of all physical and psychological findings upon clinical examination including appropriate diagnostic tests and, where possible, colour photographs of all injuries;

(d) An opinion. An interpretation as to the probable relationship of physical and psychological findings to possible torture or ill-treatment. A recommendation for any necessary medical and psychological treatment or further examination should also be given;

(e) A record of authorship. The report should clearly identify those carrying out the examination and should be signed.

84. The report should be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process should be solicited and recorded in the report. The report should be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill-treatment. It is the responsibility of the State to ensure that the report is delivered securely to these persons. The report should not be made available to any other person, except with the consent of the subject or when authorized by a court empowered to enforce the transfer. For general considerations for written reports following allegations of torture, see chapter IV. Chapters V and VI describe in detail the physical and psychological assessments, respectively.

## C. Procedures of a torture investigation

### 1. *Determination of the appropriate investigative body*

85. In cases where involvement in torture by public officials is suspected, including possible orders for the use of torture by ministers, ministerial aides, officers acting with the knowledge of ministers, senior officers in State ministries, senior military leaders or tolerance of torture by such individuals, an objective and impartial investigation may not be possible unless a special commission of inquiry is established. A commission of inquiry may also

<sup>68</sup> Under certain circumstances professional ethics may require information to be kept confidential. These requirements should be respected.

<sup>69</sup> See footnote 68.

be necessary where the expertise or the impartiality of the investigators is called into question.

86. Factors that support a belief that the State was involved in the torture or that special circumstances exist that should trigger the creation of a special impartial investigation mechanism include:

(a) Where the victim was last seen unharmed in police custody or detention;

(b) Where the *modus operandi* is recognizably attributable to State-sponsored torture;

(c) Where persons in the State or associated with the State have attempted to obstruct or delay the investigation of the torture;

(d) Where public interest would be served by an independent inquiry;

(e) Where investigation by regular investigative agencies is in question because of lack of expertise or lack of impartiality or for other reasons, including the importance of the matter, the apparent existence of a pattern of abuse, complaints from the person or the above inadequacies or other substantial reasons.

87. Several considerations should be taken into account when a State decides to establish an independent commission of inquiry. First, persons subject to an inquiry should be guaranteed the minimum procedural safeguards protected by international law at all stages of the investigation. Second, investigators should have the support of adequate technical and administrative personnel, as well as access to objective, impartial legal advice to ensure that the investigation will produce admissible evidence for criminal proceedings. Third, investigators should receive the full scope of the State's resources and powers. Finally, investigators should have the power to seek help from the international community of experts in law and medicine.

## 2. *Interviewing the alleged victim and other witnesses*

88. Because of the nature of torture cases and the trauma individuals suffer as a result, often including a devastating sense of powerlessness, it is particularly important to show sensitivity to the alleged torture victim and other witnesses. The State must protect alleged victims of torture, witnesses and their families from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Investigators must inform witnesses about the consequences of their involvement in the investigation and about any subsequent developments in the case that may affect them.

### (a) *Informed consent and other protection for the alleged victim*

89. From the outset, the alleged victim should be informed, wherever possible, of the nature of the proceedings, why his or her evidence is being sought, if and how evidence offered by the alleged victim may be used. Investigators should explain to the person which portions of the investigation will be public information and which portions will be confidential. The person has the right to refuse to cooperate with all or part of the investigation.

Every effort should be made to accommodate his or her schedule and wishes. The alleged torture victim should be regularly informed of the progress of the investigation. The alleged victim should also be notified of all key hearings in the investigation and prosecution of the case. The investigators should inform the alleged victim of the arrest of the suspected perpetrator. Alleged victims of torture should be given contact information for advocacy and treatment groups that might be of assistance to them. Investigators should work with advocacy groups within their jurisdiction to ensure that there is a mutual exchange of information and training concerning torture.

### (b) *Selection of the investigator*

90. The authorities investigating the case must identify a person primarily responsible for questioning the alleged victim. While the alleged victim may need to discuss his or her case with both legal and medical professionals, the investigating team should make every effort to minimize unnecessary repetitions of the person's story. In selecting a person as the primary investigator with responsibility for the alleged torture victim, special consideration should be given to the victim's preference for a person of the same gender, the same cultural background or the ability to communicate in his or her native language. The primary investigator should have prior training or experience in documenting torture and in working with victims of trauma, including torture. In situations where an investigator with prior training or experience is not available, the primary investigator should make every effort to become informed about torture and its physical and psychological consequences before interviewing the individual. Information about torture is available from sources including this manual, several professional and training publications, training courses and professional conferences. The investigator should also have access to international expert advice and assistance throughout the investigation.

### (c) *Context of the investigation*

91. Investigators should carefully consider the context in which they are working, take necessary precautions and provide safeguards accordingly. If interviewing people who are still imprisoned or in similar situations in which reprisals are possible, the interviewer should use care not to put them in danger. In situations where talking to an investigator may endanger someone, a "group interview" may be preferable to an individual interview. In other cases, the interviewer must choose a place for the private interview where the witness feels comfortable to talk freely.

92. Evaluations occur in a variety of political contexts. This results in important differences in the manner in which evaluations should be conducted. The legal standards under which the investigation is conducted are also affected by the context. For example, an investigation culminating in the trial of an alleged perpetrator will require the highest level of proof, whereas a report supporting an application for political asylum in a third country need provide only a relatively low level of proof of torture. The investigator must adapt the following guidelines according to the particular situation and purpose of the

evaluation. Examples of various contexts include, but are not limited to, the following:

- (i) In prison or detention in the individual's home country;
- (ii) In prison or detention in another country;
- (iii) Not in detention in the home country but in a hostile oppressive climate;
- (iv) Not in detention in the home country during a time of peace and security;
- (v) In another country that may be friendly or hostile;
- (vi) In a refugee camp setting;
- (vii) In a war crimes tribunal or truth commission.

93. The political context may be hostile towards the victim and the examiner, for example, when detainees are interviewed while they are held in prison by their governments or while they are detained by foreign governments in order to be deported. In countries where asylum-seekers are examined in order to establish evidence of torture, the reluctance to acknowledge claims of trauma and torture may be politically motivated. The possibility of further endangering the safety of the detainee is very real and must be taken into account during every evaluation. Even in cases where persons alleging torture are not in imminent danger, investigators should use great care in their contact with them. The investigator's choice of language and attitude will greatly affect the alleged victim's ability and willingness to be interviewed. The location of the interview should be as safe and comfortable as possible, including access to toilet facilities and refreshments. Sufficient time should be allotted to interview the alleged torture victim. Investigators should not expect to get the full story during the first interview. Questions of a private nature will be traumatic for the alleged victim. The investigator must be sensitive in tone, phrasing and sequencing of questions, given the traumatic nature of the alleged victim's testimony. The witness must be told of the right to stop the questioning at any time, to take a break if needed or to choose not to respond to any question.

94. Psychological counsellors or those trained in working with torture victims should be accessible, if possible, to the alleged torture victim, witnesses and members of the investigating team. Retelling the facts of the torture may cause the person to relive the experience or suffer other trauma-related symptoms (see chapter IV, sect. H). Hearing details of torture may result in secondary trauma symptoms to interviewers, and they must be encouraged to discuss their reactions with one another, respecting their professional ethical requirements of confidentiality. Wherever possible, this should be with the help of an experienced facilitator. There are two particular risks to be aware of: first, there is a danger that the interviewer may identify with those alleging torture and not be sufficiently challenging of the story; second, the interviewer may become so used to hearing histories of torture that he or she diminishes in his or her own mind the experiences of the person being interviewed.

#### (d) *Safety of witnesses*

95. The State is responsible for protecting alleged victims, witnesses and their families from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture should be removed from any position of control or power, whether direct or indirect over complainants, witnesses and their families as well as those conducting investigations. Investigators must give constant consideration to the effect of the investigation on the safety of the person alleging torture and other witnesses.

96. One suggested technique for providing a measure of safety to interviewees, including prisoners in countries in conflict situations, is to write down and keep safe the identities of people visited so that investigators can follow up on the safety of those individuals at a future return visit. Investigators must be allowed to talk to anyone and everyone, freely and in private, and be allowed to repeat the visit to these same persons (thus the need for traceable identities of those interviewed) as the need arises. Not all countries accept these conditions, and investigators may find it difficult to obtain similar guarantees. In cases in which witnesses are likely to be put in danger because of their testimony, the investigator should seek other forms of evidence.

97. Prisoners are in greater potential danger than persons who are not in custody. Prisoners might have different reactions to different situations. In one situation, prisoners may unwittingly put themselves in danger by speaking out too rashly, thinking they are protected by the very presence of the "outside" investigator. This may not be the case. In other situations, investigators may come up against a "wall of silence", as prisoners are far too intimidated to trust anyone, even when offered talks in private. In the latter case, it may be necessary to start with "group interviews", so as to be able to explain clearly the scope and purpose of the investigation and subsequently offer to have interviews in private with those persons who desire to speak. If the fear of reprisals, justified or not, is too great, it may be necessary to interview all prisoners in a given place of custody, so as not to pinpoint any specific person. Where an investigation leads to prosecution or another public truth-telling forum, the investigator should recommend measures to prevent harm to the alleged torture victim by such means as expunging names and other information that identifies the person from the public records or offering the person an opportunity to testify through image or voice-altering devices or closed circuit television. These measures must be consistent with the rights of the accused.

#### (e) *Use of interpreters*

98. Working through an interpreter when investigating torture is not easy, even with professionals. It will not always be possible to have interpreters on hand for all different dialects and languages, and sometimes it may be necessary to use interpreters from the person's family or cultural group. This is not ideal, as the person may not always feel comfortable talking about the torture experience through people he or she knows. Ideally, the interpreter should be part of the investigating team and knowl-

edgeable about torture issues (see chapters IV, sect. I, and VI, sect. C.2).

(f) *Information to be obtained from the person alleged to have been tortured*

99. The investigator should attempt to obtain as much of the following information as possible through the testimony of the alleged victim (see chapter IV, sect. E):

- (i) The circumstances leading up to the torture, including arrest or abduction and detention;
- (ii) Approximate dates and times of the torture, including when the last instance of torture occurred. Establishing this information may not be easy, as there may be several places and perpetrators (or groups of perpetrators) involved. Separate stories may have to be recorded about the different places. Expect chronologies to be inaccurate and sometimes even confusing; notions of time are often hard to focus on for someone who has been tortured. Separate stories about different places may be useful when trying to get a global picture of the situation. Survivors will often not know exactly to where they were taken, having been blindfolded or semi-conscious. By putting together converging testimonies, it may be possible to "map out" specific places, methods and even perpetrators;
- (iii) A detailed description of the persons involved in the arrest, detention and torture, including whether he or she knew any of them prior to the events relating to the alleged torture, clothing, scars, birthmarks, tattoos, height, weight (the person may be able to describe the torturer in relation to his or her own size), anything unusual about the perpetrator's anatomy, language and accent and whether the perpetrators were intoxicated at any time;
- (iv) Contents of what the person was told or asked. This may provide relevant information when trying to identify secret or unacknowledged places of detention;
- (v) A description of the usual routine in the place of detention and the pattern of ill-treatment;
- (vi) A description of the facts of the torture, including the methods of torture used. This is understandably often difficult, and investigators should not expect to obtain the full story during one interview. It is important to obtain precise information, but questions related to intimate humiliation and assault will be traumatic, often extremely so;
- (vii) Whether the individual was sexually assaulted. Most people will tend to answer a question on sexual assault as meaning actual rape or sodomy. Investigators should be sensitive to the fact that verbal assaults, disrobing, groping, lewd or humiliating acts or blows or electric shocks to the genitals are often not taken by the victim as constituting sexual assault. These acts all violate the individual's intimacy and should be considered as being part and parcel of sexual assault. Very often, victims of sexual assault will say

nothing or even deny any sexual assault. It is often only on the second or even third visit, if the contact made has been empathic and sensitive to the person's culture and personality, that more of the story will come out;

- (viii) Physical injuries sustained in the course of the torture;
- (ix) A description of weapons or other physical objects used;
- (x) The identity of witnesses to the events involving torture. The investigator must use care in protecting the safety of witnesses and should consider encrypting the identities of witnesses or keeping these names separate from the substantive interview notes.

(g) *Statement from the person who is alleging torture*

100. The investigator should tape-record a detailed statement from the person and have it transcribed. The statement should be based on answers given in response to non-leading questions. Non-leading questions do not make assumptions or conclusions and allow the person to offer the most complete and unbiased testimony. Examples of non-leading questions are "What happened to you and where?" rather than "Were you tortured in prison?". The latter question assumes that what happened to the witness was torture and limits the location of the actions to a prison. Avoid asking questions with lists, as this can force the individual into giving inaccurate answers if what actually happened does not exactly match one of the options. Allow the person to tell his or her own story, but assist by asking questions that increase in specificity. Encourage the person to use all his/her senses in describing what has happened to him or her. Ask what he or she saw, smelled, heard and felt. This is important, for instance, in situations where the person may have been blindfolded or experienced the assault in the dark.

(h) *Alleged perpetrator's statement*

101. If possible, the investigators should interview the alleged perpetrators. The investigators must provide them with legal protections guaranteed under international and national law.

### 3. *Securing and obtaining physical evidence*

102. The investigator should gather as much physical evidence as possible to document an incident or pattern of torture. One of the most important aspects of a thorough and impartial investigation of torture is the collection and analysis of physical evidence. Investigators should document the chain of custody involved in recovering and preserving physical evidence in order to use such evidence in future legal proceedings, including potential criminal prosecution. Most torture occurs in places where people are held in some form of custody, where preservation of physical evidence or unrestricted access may be initially difficult or even impossible. Investigators must be given authority by the State to obtain unrestricted access to any place or premises and be able to secure the setting where torture allegedly took place. Investigative personnel and other investigators should coordinate their efforts in

carrying out a thorough investigation of the place where torture allegedly occurred. Investigators must have unrestricted access to the alleged scene of torture. Their access must include, but not be limited to, open or closed areas, including buildings, vehicles, offices, prison cells or other premises where torture is alleged to have taken place.

103. Any building or area under investigation must be closed off so as not to lose any possible evidence. Only investigators and their staff should be allowed entry into the area once it has been designated as under investigation. Examination of the scene for any material evidence should take place. All evidence must be properly collected, handled, packaged, labelled and placed in safe-keeping to prevent contamination, tampering or loss of evidence. If the torture has allegedly taken place recently enough for such evidence to be relevant, any samples found of body fluids (such as blood or semen), hair, fibres and threads should be collected, labelled and properly preserved. Any implements that could be used to inflict torture, whether they be destined for that purpose or used circumstantially, should be taken and preserved. If recent enough to be relevant, any fingerprints located must be lifted and preserved. A labelled sketch of the premises or place where torture has allegedly taken place must be made to scale, showing all relevant details, such as the location of the floors in a building, rooms, entrances, windows, furniture and surrounding terrain. Colour photographs must also be taken to record the same. A record of the identity of all persons at the alleged torture scene must be made, including complete names, addresses and telephone numbers or other contact information. If torture is recent enough for it to be relevant, an inventory of the clothing of the person alleging torture should be taken and tested at a laboratory, if available, for bodily fluids and other physical evidence. Information must be obtained from anyone present on the premises or in the area under investigation to determine whether they were witness to the incidents of alleged torture. Any relevant papers, records or documents should be saved for evidential use and handwriting analysis.

#### 4. *Medical evidence*

104. The investigator should arrange for a medical examination of the alleged victim. The timeliness of such medical examination is particularly important. A medical examination should be undertaken regardless of the length of time since the torture, but if it is alleged to have happened within the past six weeks, such an examination should be arranged urgently before acute signs fade. The examination should include an assessment of the need for treatment of injuries and illnesses, psychological help, advice and follow-up (see chapter V for a description of the physical examination and forensic evaluation). A psychological appraisal of the alleged torture victim is always necessary and may be part of the physical examination, or where there are no physical signs, may be performed by itself (see chapter VI for a description of the psychological evaluation).

105. In formulating a clinical impression for the purpose of reporting physical and psychological evidence of torture, there are six important questions to ask:

- (a) Are the physical and psychological findings consistent with the alleged report of torture?
- (b) What physical conditions contribute to the clinical picture?
- (c) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
- (d) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where in the course of recovery is the individual?
- (e) What other stressful factors are affecting the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.)? What impact do these issues have on the victim?
- (f) Does the clinical picture suggest a false allegation of torture?

#### 5. *Photography*

106. Colour photographs should be taken of the injuries of persons alleging that they have been tortured, of the premises where torture has allegedly occurred (interior and exterior) and of any other physical evidence found there. A measuring tape or some other means of showing scale on the photograph is essential. Photographs must be taken as soon as possible, even with a basic camera, because some physical signs fade rapidly and locations can be interfered with. Instantly developed photos may decay over time. More professional photos are preferred and should be taken as soon as the equipment becomes available. If possible, photographs should be taken using a 35-millimetre camera with an automatic date feature. The chain of custody of the film, negatives and prints must be fully documented.

### D. *Commission of inquiry*

#### 1. *Defining the scope of the inquiry*

107. States and organizations establishing commissions of inquiry need to define the scope of the inquiry by including terms of reference in their authorization. Defining the commission's terms of reference can greatly increase its success by giving legitimacy to the proceedings, assisting commission members in reaching a consensus on the scope of the inquiry and providing a measure by which the commission's final report can be judged. Recommendations for defining terms of reference are as follows:

- (a) They should be neutrally framed so that they do not suggest a predetermined outcome. To be neutral, terms of reference must not limit investigations in areas that might uncover State responsibility for torture;
- (b) They should state precisely which events and issues are to be investigated and addressed in the commission's final report;
- (c) They should provide flexibility in the scope of inquiry to ensure that thorough investigation by the com-

mission is not hampered by overly restrictive or overly broad terms of reference. The necessary flexibility may be accomplished, for example, by permitting the commission to amend its terms of reference as necessary. It is important, however, for the commission to keep the public informed of any amendments to its mandate.

## 2. *The power of the commission*

108. Principles should set out the powers of the commission in a general manner. The commission specifically needs the following:

(a) Authority to obtain all information necessary to the inquiry including the authority to compel testimony under legal sanction, to order the production of documents including State and medical records, and to protect witnesses, families of the victim and other sources;

(b) Authority to issue a public report;

(c) Authority to conduct on-site visits, including at the location where the torture is suspected to have occurred;

(d) Authority to receive evidence from witnesses and organizations located outside the country.

## 3. *Membership criteria*

109. Commission members should be chosen for their recognized impartiality, competence and independence as individuals as defined as follows:

(a) Impartiality. Commission members should not be closely associated with any individual, State entity, political party or other organization potentially implicated in the torture. They should not be too closely connected to an organization or group of which the victim is a member, as this may damage the commission's credibility. This should not, however, be an excuse for blanket exclusions from the commission, for instance, of members of large organizations of which the victim is also a member or of persons associated with organizations dedicated to the treatment and rehabilitation of torture victims;

(b) Competence. Commission members must be capable of evaluating and weighing evidence and exercising sound judgement. If possible, commissions of inquiry should include individuals with expertise in law, medicine and other appropriate specialized fields;

(c) Independence. Members of the commission should have a reputation in their community for honesty and fairness.

110. The objectivity of the investigation and the commission's findings may, among other things, depend on whether it has three or more members rather than one or two. A single commissioner should in general not conduct investigations into torture. A single, isolated commissioner will generally be limited in the depth of the investigation that he or she can conduct alone. In addition, a single commissioner will have to make controversial and important decisions without debate and will be particularly vulnerable to State and other outside pressure.

## 4. *The commission's staff*

111. Commissions of inquiry should have impartial, expert counsel. Where the commission is investigating allegations of State misconduct, it would be advisable to appoint counsel outside the Ministry of Justice. The chief counsel to the commission should be insulated from political influence, through civil service tenure or as a wholly independent member of the bar. The investigation will often require expert advisers. Technical expertise should be available to the commission in areas such as pathology, forensic science, psychiatry, psychology, gynaecology and paediatrics. To conduct a completely impartial and thorough investigation, the commission would almost always need its own investigators to pursue leads and develop evidence. The credibility of an inquiry would thus be significantly enhanced to the extent that the commission would be able to rely on its own investigators.

## 5. *Protection of witnesses*

112. The State shall protect complainants, witnesses, those conducting the investigation and their families from violence, threats of violence or any other form of intimidation (see section C.2 (d) above). If the commission concludes that there is a reasonable fear of persecution, harassment or harm to any witness or prospective witness, the commission may find it advisable to hear the evidence in camera, keep the identity of an informant or witness confidential, use only evidence that will not risk identifying the witness and take other appropriate measures.

## 6. *Proceedings*

113. It follows from general principles of criminal procedure that hearings should be conducted in public, unless in-camera proceedings are necessary to protect the safety of a witness. In-camera proceedings should be recorded and the sealed, unpublished record kept in a known location. Occasionally, complete secrecy may be required to encourage testimony, and the commission may want to hear witnesses privately, informally or without recording testimony.

## 7. *Notice of inquiry*

114. Wide notice of the establishment of a commission and the subject of the inquiry should be given. The notice should include an invitation to submit relevant information and written statements to the commission and instructions to persons willing to testify. Notice can be disseminated through newspapers, magazines, radio, television, leaflets and posters.

## 8. *Receipt of evidence*

115. Commissions of inquiry should have the power to compel testimony and produce documents, plus the authority to compel testimony from officials allegedly involved in torture. Practically, this authority may involve the power to impose fines or sentences if government officials or other individuals refuse to comply. Commissions

of inquiry should invite persons to testify or submit written statements as a first step in gathering evidence. Written statements may become an important source of evidence if their authors are afraid to testify, cannot travel to proceedings or are otherwise unavailable. Commissions of inquiry should review other proceedings that could provide relevant information.

#### 9. *Rights of parties*

116. Those alleging that they have been tortured and their legal representatives should be informed of and have access to any hearing and all information relevant to the investigation and must be entitled to present evidence. This particular emphasis on the role of the survivor as a party to the proceedings reflects the especially important role his/her interests play in the conduct of the investigation. However, all other interested parties should also have an opportunity to be heard. The investigative body must be entitled to issue summonses to witnesses, including the officials allegedly involved, and to demand the production of evidence. All these witnesses should be permitted legal counsel if they are likely to be harmed by the inquiry, for example, when their testimony could expose them to criminal charges or civil liability. Witnesses may not be compelled to testify against themselves. There should be an opportunity for the effective questioning of witnesses by the commission. Parties to the inquiry should be allowed to submit written questions to the commission.

#### 10. *Evaluation of evidence*

117. The commission must assess all information and evidence it receives to determine reliability and probity. The commission should evaluate oral testimony, taking into account the demeanour and overall credibility of the witness. The commission must be sensitive to social, cultural and gender issues that affect demeanour. Corroboration of evidence from several sources will increase the probative value of such evidence and the reliability of

hearsay evidence. The reliability of hearsay evidence must be considered carefully before the commission accepts it as fact. Testimony not tested by cross-examination must also be viewed with caution. In-camera testimony preserved in a closed record or not recorded at all is often not subject to cross-examination and, therefore, may be given less weight.

#### 11. *Report of the commission*

118. The commission should issue a public report within a reasonable period of time. Furthermore, when the commission is not unanimous in its findings, the minority commissioners should file a dissenting opinion. Commission of inquiry reports should contain, at a minimum, the following information:

- (a) The scope of inquiry and terms of reference;
- (b) The procedures and methods of evaluating evidence;
- (c) A list of all witnesses, including age and gender, who have testified, except for those whose identities are withheld for protection or who have testified in camera, and exhibits received as evidence;
- (d) The time and place of each sitting (this might be annexed to the report);
- (e) The background of the inquiry, such as relevant social, political and economic conditions;
- (f) The specific events that occurred and the evidence upon which such findings are based;
- (g) The law upon which the commission relied;
- (h) The commission's conclusions based on applicable law and findings of fact;
- (i) Recommendations based on the findings of the commission.

119. The State should reply publicly to the commission's report and, where appropriate, indicate which steps it intends to take in response to the report.



## CHAPTER IV

**GENERAL CONSIDERATIONS FOR INTERVIEWS**

120. When a person who has allegedly been tortured is interviewed, there are a number of issues and practical factors that have to be taken into consideration. These considerations apply to all persons carrying out interviews, whether they are lawyers, medical doctors, psychologists, psychiatrists, human rights monitors or members of any other profession. The following section takes up this “common ground” and attempts to put it into contexts that may be encountered when investigating torture and interviewing victims of torture.

**A. Purpose of inquiry, examination and documentation**

121. The broad purpose of the investigation is to establish the facts related to alleged incidents of torture (see chapter III, sect. D). Medical evaluations of torture may be useful evidence in legal contexts such as:

- (a) Identifying the perpetrators responsible for torture and bringing them to justice;
- (b) Support of political asylum applications;
- (c) Establishing conditions under which false confessions may have been obtained by State officials;
- (d) Establishing regional practices of torture. Medical evaluations may also be used to identify the therapeutic needs of survivors and as testimony in human rights investigations.

122. The purpose of the written or oral testimony of the physician is to provide expert opinion on the degree to which medical findings correlate with the patient’s allegation of abuse and to communicate effectively the physician’s medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials and the local and international communities on the physical and psychological sequelae of torture. The examiner should be prepared to do the following:

- (a) Assess possible injury and abuse, even in the absence of specific allegations by individuals, law enforcement or judicial officials;
- (b) Document physical and psychological evidence of injury and abuse;
- (c) Correlate the degree of consistency between examination findings and specific allegations of abuse by the patient;

(d) Correlate the degree of consistency between individual examination findings with the knowledge of torture methods used in a particular region and their common after-effects;

(e) Render expert interpretation of the findings of medical-legal evaluations and provide expert opinion regarding possible causes of abuse in asylum hearings, criminal trials and civil proceedings;

(f) Use information obtained in an appropriate manner to enhance fact-finding and further documentation of torture.

**B. Procedural safeguards with respect to detainees**

123. Forensic medical evaluation of detainees should be conducted in response to official written requests by public prosecutors or other appropriate officials. Requests for medical evaluations by law enforcement officials are to be considered invalid unless they are requested by written orders of a public prosecutor. Detainees themselves, their lawyers or relatives, however, have the right to request a medical evaluation to seek evidence of torture and ill-treatment. The detainee should be taken to the forensic medical examination by officials other than soldiers and police since torture and ill-treatment may have occurred in the custody of these officials and, therefore, that would place unacceptable coercive pressures on the detainee or the physician not to document torture or ill-treatment effectively. The officials who supervise the transportation of the detainee should be responsible to the public prosecutors and not to other law enforcement officials. The detainee’s lawyer should be present during the request for examination and post-examination transport of the detainee. Detainees have the right to obtain a second or alternative medical evaluation by a qualified physician during and after the period of detention.

124. Each detainee must be examined in private. Police or other law enforcement officials should never be present in the examination room. This procedural safeguard may be precluded only when, in the opinion of the examining doctor, there is compelling evidence that the detainee poses a serious safety risk to health personnel. Under such circumstances, security personnel of the health facility, not the police or other law enforcement officials, should be available upon the medical examiner’s request. In such cases, security personnel should still remain out of earshot (i.e. be only within visual contact) of the patient. Medical evaluation of detainees should be conducted at a location that the physician deems most

suitable. In some cases, it may be best to insist on evaluation at official medical facilities and not at the prison or jail. In other cases, prisoners may prefer to be examined in the relative safety of their cell, if they feel the medical premises may be under surveillance, for example. The best place will be dictated by many factors, but in all cases, investigators should ensure that prisoners are not forced into accepting a place with which they are not comfortable.

125. The presence of police officers, soldiers, prison officers or other law enforcement officials in the examination room, for whatever reason, should be noted in the physician's official medical report. Their presence during the examination may be grounds for disregarding a negative medical report. The identity and titles of others who are present in the examination room during the medical evaluations should be indicated in the report. Medical-legal evaluations of detainees should include the use of a standardized medical report form (see annex IV for guidelines that may be used to develop standard medical report forms).

126. The original, completed evaluation should be transmitted directly to the person requesting the report, generally the public prosecutor. When a detainee or a lawyer acting on his or her behalf requests a medical report, the report must be provided. Copies of all medical reports should be retained by the examining physician. A national medical association or a commission of inquiry may choose to audit medical reports to ensure that adequate procedural safeguards and documentation standards are adhered to, particularly by doctors employed by the State. Reports should be sent to such an organization, provided the issues of independence and confidentiality have been addressed. Under no circumstances should a copy of the medical report be transferred to law enforcement officials. It is mandatory that a detainee undergo a medical examination at the time of detention and an examination and evaluation upon release.<sup>70</sup> Access to a lawyer should be provided at the time of the medical examination. An outside presence during examination may be impossible in most prison situations. In such cases, it should be stipulated that prison doctors working with prisoners should respect medical ethics, and should be capable of carrying out their professional duties independently of any third-party influence. If the forensic medical examination supports allegations of torture, the detainee should not be returned to the place of detention, but rather should appear before the prosecutor or judge to determine the detainee's legal disposition.<sup>71</sup>

### C. Official visits to detention centres

127. Visits to prisoners are not to be considered lightly. They can in some cases be notoriously difficult to carry out in an objective and professional way, particularly in countries where torture is still being practised.

<sup>70</sup> See the United Nations Standard Minimum Rules for the Treatment of Prisoners (chap. I, sect. B).

<sup>71</sup> "Health care for prisoners: implications of Kalk's refusal", *The Lancet*, vol. 337 (1991), pp. 647-648.

One-off visits, without follow-up to ensure the safety of the interviewees after the visit, may be dangerous. In some cases, one visit without a repeat visit may be worse than no visit at all. Well-meaning investigators may fall into the trap of visiting a prison or police station, without knowing exactly what they are doing. They may obtain an incomplete or false picture of reality. They may inadvertently place prisoners that they may never visit again in danger. They may give an alibi to the perpetrators of torture, who may use the fact that outsiders visited their prison and saw nothing.

128. Visits should best be left to investigators who can carry them out and follow them up in a professional way and who have certain weathered procedural safeguards for their work. The notion that some evidence is better than no evidence is not valid when working with prisoners who might be put in danger by giving testimony. Visits to detention facilities by well-meaning people representing official and non-governmental institutions can be difficult and, worse, can be counter-productive. In the case in point here, a distinction should be made between a bona fide visit necessary for the inquiry, which is not in question, and a non-essential visit that goes beyond that, which when made by non-specialists could cause more harm than good in a country that practises torture. Independent commissions constituted by jurists and physicians should be given ensured periodic access to visit places of detention and prisons.

129. Interviews with people who are still in custody, and possibly even in the hands of the perpetrators of torture will obviously be very different from interviews in the privacy and security of an outside, safe medical facility. The importance of obtaining the person's trust in such situations cannot be stressed enough. However, it is even more important not, even unwittingly, to betray that trust. All precautions should be taken to ensure that detainees do not place themselves in danger. Detainees who have been tortured should be asked whether the information can be used and in what way. They may be too afraid to allow use of their names, fearing reprisals for example. Investigators, clinicians and interpreters are bound to respect that which has been promised to the detainee.

130. A clear dilemma may arise if, for example, it is evident that a large number of prisoners have been tortured in a given place, but they all refuse to allow investigators to use their stories because of fear. The options are either betraying the prisoners' trust in the effort to stop torture or respecting trust and going away without saying anything; a useful way has to be found out of this dilemma. When confronted with a number of prisoners with clear signs on their bodies of whippings, beatings, lacerations caused by canings, etc., but who all refuse mention of their cases out of fear of reprisal, it is useful to organize a "health inspection" of the whole ward in full view in the courtyard. In that way, the visiting medical investigator walking through the ranks and directly observing the very visible signs of torture on the backs of the prisoners is able to make a report on what he has seen and will not have to say that prisoners complained about torture. This first step ensures the prisoners' trust for future follow-up visits.

131. Other more subtle forms of torture, psychological or sexual, for example, clearly cannot be dealt with in the same way. In these cases, it may be necessary for investigators to refrain from comment for one or several visits until the circumstances allow or encourage detainees to be less afraid and to authorize the use of their stories. The physician and interpreter should provide their names and explain their role in conducting the evaluation. Documentation of medical evidence of torture requires specific knowledge by licensed health practitioners. Knowledge of torture and its physical and psychological consequences can be gained through publications, training courses, professional conferences and experience. In addition, knowledge about regional practices of torture and ill-treatment is important because such information may corroborate an individual's accounts of these. Experience in interviewing and examining individuals for physical and psychological evidence of torture and in documenting findings should be acquired under the supervision of experienced clinicians.

132. Those still in custody may sometimes be too trusting in situations where the interviewer simply cannot guarantee that there will be no reprisals, if a repeat visit has not been negotiated and fully accepted by the authorities or if the person's identity has not been recorded so as to ensure follow-up, for example. Every precaution should be taken to be sure that prisoners do not place themselves at risk unnecessarily, naively trusting an outsider to protect them.

133. Ideally, when visits are made to people still in custody the interpreters should be outsiders and not recruited locally. This is mainly to avoid them or their families being put under pressure from inquisitive authorities wanting to know what information was given to the investigators. The issue may be more complex when the detainees are from a different ethnic group than their jailers. Should the local interpreter be from the same ethnic group as the prisoner, so as to gain his/her trust, but at the same time arousing the mistrust of the authorities who would possibly attempt to intimidate the interpreter? Furthermore, the interpreter may be reluctant to work in a hostile environment, which would potentially place him or her at risk. Or should the interpreter come from the same ethnic group as the captors, thereby gaining trust, but losing that of the prisoner, while still leaving the interpreter vulnerable to intimidation by the authorities? The answer is obviously and ideally neither of the above. Interpreters should be from outside the region and seen by all to be as independent as the investigators.

134. A person interviewed at 8 p.m. deserves as much attention as one seen at 8 a.m. Investigators should arrange to have enough time and not overwork themselves. It is unfair to the 8 p.m. person (who in addition has been waiting all day to tell his or her story) to be cut short because of the time. Similarly, the nineteenth story about *falanga* deserves as much attention as the first. Prisoners who do not often see outsiders may never have had a chance to talk about their torture. It is an erroneous assumption to think that prisoners talk constantly among themselves about torture. Prisoners who have nothing new to offer the investigation deserve as much time as the other prisoners.

## D. Techniques of questioning

135. Several basic rules must be respected (see chapter III, sect. C.2 (g)). Information is certainly important, but the person being interviewed is even more so, and listening is more important than asking questions. If only questions are asked, all that are obtained are answers. To the detainee, it may be more important to talk about family than to talk about torture. This should be duly considered, and time should be allowed for some discussion of personal matters. Torture, particularly sexual torture, is a very intimate subject and may not come up before a follow-up visit or even later. Individuals should not be forced to talk about any form of torture if they feel uncomfortable about it.

## E. Documenting the background

### 1. Psychosocial history and pre-arrest

136. If an alleged torture victim is no longer in custody, the examiner should inquire into the person's daily life, relations with friends and family, work or school, occupation, interests, future plans and use of alcohol and drugs. Information should also be elicited regarding the person's post-detention psychosocial history. When an individual is still in custody, a more limited psychosocial history regarding occupation and literacy is sufficient. Inquire about prescription medication being taken by the patient; this is particularly important because such medications may be denied to a person in custody, with significant adverse health consequences. Inquiries into political activities, beliefs and opinions are relevant insofar as they help to explain why a person was detained or tortured, but such inquiries are best made indirectly by asking the person which accusations were made or why they think they were detained and tortured.

### 2. Summary of detention and abuse

137. Before obtaining a detailed account of events, elicit summary information, including dates, places, duration of detention, frequency and duration of torture sessions. A summary will help to make effective use of time. In some cases in which survivors have been tortured on multiple occasions, they may be able to recall what happened to them, but often they cannot recall exactly where and when each event occurred. In such circumstances, it may be advisable to elicit the historical account according to methods of abuse rather than relating a series of events during specific arrests. Similarly, in writing up the story it may often be useful to have "what happened where" documented as much as possible. Holding places are operated by different security, police or armed forces, and what happened in different places may be useful for a full picture of the torture system. Obtaining a map of where the torture occurred may be useful in piecing together the stories of different people. This will often prove very useful for the overall investigation.

### 3. *Circumstances of detention*

138. Consider the following questions: what time was it? Where were you? What were you doing? Who was there? Describe the appearance of those who detained you. Were they military or civilian, in uniform or in street clothes? What type of weapons were they carrying? What was said? Any witnesses? Was this a formal arrest, administrative detention or disappearance? Was violence used, threats spoken? Was there any interaction with family members? Note the use of restraints or blindfold, means of transportation, destination and names of officials, if known.

### 4. *Place and conditions of detention*

139. Include access to and descriptions of food and drink, toilet facilities, lighting, temperature and ventilation. Also, document any contact with family, lawyers or health professionals, conditions of overcrowding or solitary confinement, dimensions of the detention place and whether there are other people who can corroborate the detention. Consider the following questions: what happened first? Where were you taken? Was there an identification process (personal information recorded, fingerprints, photographs)? Were you asked to sign anything? Describe the conditions of the cell or room (note size, others present, light, ventilation, temperature, presence of insects, rodents, bedding and access to food, water and toilet). What did you hear, see and smell? Did you have any contact with people outside or access to medical care? What was the physical layout of the place where you were detained?

### 5. *Methods of torture and ill-treatment*

140. In obtaining background information on torture and ill-treatment, caution should be used about suggesting forms of abuse to which a person may have been subjected. This may help separate potential embellishment from valid experiences. However, eliciting negative responses to questions about various forms of torture may also help establish the credibility of the person. Questions should be designed to elicit a coherent narrative account. Consider the following questions. Where did the abuse take place, when and for how long? Were you blindfolded? Before discussing forms of abuse, note who was present (give names, positions). Describe the room or place. Which objects did you observe? If possible, describe each instrument of torture in detail; for electrical torture, the current, device, number and shape of electrodes. Ask about clothing, disrobing and change of clothing. Record quotations of what was said during interrogation, insults hurled at the victim, etc. What was said among the perpetrators?

141. For each form of abuse, note: body position, restraint, nature of contact, including duration, frequency, anatomical location and the area of the body affected. Was there any bleeding, head trauma or loss of consciousness? Was the loss of consciousness due to head trauma, asphyxiation or pain? The investigator should also ask about how the person was at the end of the "session". Could he or she walk? Did he or she have to be helped or

carried back to the cell? Could he or she get up the next day? How long did the feet stay swollen? All this gives a certain completeness to the description, which a checklist of methods does not. The history should include the date of positional torture, how many times and for how many days the torture lasted, the period of each episode, the style of the suspension (reverse-linear, being covered by thick cloth-blanket or being tied directly with a rope, putting weight on the legs or pulling down) or position. In cases of suspension torture, ask which sort of material was used (rope, wire and cloth leave different marks, if any, on the skin after suspension). The examiner must remember that statements on the length of the torture session by the torture survivor are subjective and may not be correct, since disorientation of time and place during torture is a generally observed finding. Was the person sexually assaulted in any manner? Elicit what was said during the torture. For example, during electric shock torture to the genitals, perpetrators often tell their torture victims that they will no longer have normal sexual relations or something similar. For a detailed discussion of the assessment of an allegation of sexual torture, including rape, see chapter V, sect. D.8.

## F. *Assessment of the background*

142. Torture survivors may have difficulty recounting the specific details of the torture for several important reasons, including:

- (a) Factors during torture itself, such as blindfolding, drugging, lapses of consciousness, etc.;
- (b) Fear of placing themselves or others at risk;
- (c) A lack of trust in the examining clinician or interpreter;
- (d) The psychological impact of torture and trauma, such as high emotional arousal and impaired memory, secondary to trauma-related mental illnesses, such as depression and post-traumatic stress disorder (PTSD);
- (e) Neuropsychiatric memory impairment from beatings to the head, suffocation, near drowning or starvation;
- (f) Protective coping mechanisms, such as denial and avoidance;
- (g) Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.<sup>72</sup>

143. Inconsistencies in a person's story may arise from any or all of these factors. If possible, the investigator should ask for further clarification. When this is not possible, the investigator should look for other evidence that supports or refutes the story. A network of consistent supporting details can corroborate and clarify the person's story. Although the individual may not be able to provide the details desired by the investigator, such as dates, times, frequencies and exact identities of perpetrators, a broad outline of the traumatic events and torture will emerge and stand up over time.

<sup>72</sup> R. F. Mollica and Y. Caspi-Yavin, "Overview: the assessment and diagnosis of torture events and symptoms", in *Torture and Its Consequences: Current Treatment Approaches*, M. Başoğlu, ed. (Cambridge, Cambridge University Press, 1992), pp. 38-55.

## G. Review of torture methods

144. After eliciting a detailed narrative account of events, it is advisable to review other possible torture methods. It is essential to learn about regional practices of torture and modify local guidelines accordingly. Questioning about specific forms of torture is helpful when:

- (a) Psychological symptoms cloud recollections;
- (b) The trauma was associated with impaired sensory capabilities;
- (c) There is a case of possible organic brain damage;
- (d) There are mitigating educational and cultural factors.

145. The distinction between physical and psychological methods is artificial. For example, sexual torture generally causes both physical and psychological symptoms, even when there has been no physical assault. The following list of torture methods is given to show some of the categories of possible abuse. It is not meant to be used by investigators as a checklist or as a model for listing torture methods in a report. A method-listing approach may be counter-productive, as the entire clinical picture produced by torture is much more than the simple sum of lesions produced by methods on a list. Indeed, experience has shown that when confronted with such a "package-deal" approach to torture, perpetrators often focus on one of the methods and argue about whether that particular method is a form of torture. Torture methods to consider include, but are not limited to:

- (a) Blunt trauma, such as a punch, kick, slap, whipping, a beating with wires or truncheons or falling down;
- (b) Positional torture, using suspension, stretching limbs apart, prolonged constraint of movement, forced positioning;
- (c) Burns with cigarettes, heated instruments, scalding liquid or a caustic substance;
- (d) Electric shocks;
- (e) Asphyxiation, such as wet and dry methods, drowning, smothering, choking or use of chemicals;
- (f) Crush injuries, such as smashing fingers or using a heavy roller to injure the thighs or back;
- (g) Penetrating injuries, such as stab and gunshot wounds, wires under nails;
- (h) Chemical exposure to salt, chilli pepper, gasoline, etc. (in wounds or body cavities);
- (i) Sexual violence to genitals, molestation, instrumentation, rape;
- (j) Crush injury or traumatic removal of digits and limbs;
- (k) Medical amputation of digits or limbs, surgical removal of organs;
- (l) Pharmacological torture using toxic doses of sedatives, neuroleptics, paralytics, etc.;
- (m) Conditions of detention, such as a small or overcrowded cell, solitary confinement, unhygienic conditions, no access to toilet facilities, irregular or contaminated

food and water, exposure to extremes of temperature, denial of privacy and forced nakedness;

(n) Deprivation of normal sensory stimulation, such as sound, light, sense of time, isolation, manipulation of brightness of the cell, abuse of physiological needs, restriction of sleep, food, water, toilet facilities, bathing, motor activities, medical care, social contacts, isolation within prison, loss of contact with the outside world (victims are often kept in isolation in order to prevent bonding and mutual identification and to encourage traumatic bonding with the torturer);

(o) Humiliation, such as verbal abuse, performance of humiliating acts;

(p) Threats of death, harm to family, further torture, imprisonment, mock executions;

(q) Threats of attack by animals, such as dogs, cats, rats or scorpions;

(r) Psychological techniques to break down the individual, including forced betrayals, accentuating feelings of helplessness, exposure to ambiguous situations or contradictory messages;

(s) Violation of taboos;

(t) Behavioural coercion, such as forced engagement in practices against the religion of the victim (e.g. forcing Muslims to eat pork), forced harm to others through torture or other abuses, forced destruction of property, forced betrayal of someone placing them at risk of harm;

(u) Forcing the victim to witness torture or atrocities being inflicted on others.

## H. Risk of re-traumatization of the interviewee

146. Taking into consideration that lesions of different types and levels may occur according to the methods of torture practised, the data acquired subsequent to a comprehensive medical history and physical examination should be assessed together with appropriate laboratory and radiological examinations. Providing information and making explanations for each process to be applied during the medical examination and ensuring detailed awareness about the laboratory methods play a significant role (see chapter VI, sect. B.2 (a)).

147. The presence of psychological sequelae in torture survivors, particularly the various manifestations of PTSD, may cause the torture survivor to fear experiencing a re-enactment of his or her torture experience during the interview, physical examination or laboratory test. Explaining to the torture survivor what he or she should expect prior to the medical examination is an important component of the process. Those who survive torture and remain in their country may experience intense fear and suspicion about being re-arrested, and they are often forced to go underground to avoid being arrested again. Those who are exiled or refugees may leave behind their native language, culture, family, friends, work and everything that is familiar to them.

148. The torture survivor's personal reactions to the interviewer (and the interpreter, in cases where one is used) can have an effect on the interview process and, in

turn, the outcome of the investigation. Likewise, the personal reactions of the investigator towards the person can also affect the process of the interview and the outcome of the investigation. It is important to examine the barriers to effective communication and the understanding that these personal reactions might impose on an investigation. The investigator should maintain an ongoing examination of the interview and investigation process through consultation and discussion with colleagues familiar with the field of psychological assessment and treatment of torture survivors. This type of peer supervision can be an effective means of monitoring the interview and investigation process for biases and barriers to effective communication and for obtaining accurate information (see chapter VI, sect. C.2).

149. Despite all precautions, physical and psychological examinations by their very nature may re-traumatize the patient by provoking or exacerbating symptoms of post-traumatic stress by reviving painful effects and memories (see chapter VI, sect. B.2). Questions about psychological distress and, especially, about sexual matters are considered taboo in most traditional societies, and the asking of such questions is regarded as irreverent or insulting. If sexual torture was part of the violations incurred, the claimant may feel irredeemably stigmatized and tainted in his or her moral, religious, social or psychological integrity. The expression of a respectful awareness of these conditions, as well as the clarification of confidentiality and its limits, are, therefore, of paramount importance for a well-conducted interview. A subjective assessment has to be made by the evaluator about the extent to which pressing for details is necessary for the effectiveness of the report in court, especially if the claimant demonstrates obvious signs of distress in the interview.

### **I. Use of interpreters**

150. For many purposes, it is necessary to use an interpreter to allow the interviewer to understand what is being said. Although the interviewer and the interviewee may share a little of a common language, the information being sought is often too important to risk the errors that arise from an incomplete understanding of one another. Interpreters must be advised that what they hear and interpret in interviews is strictly confidential. It is the interpreters who get all the information, first-hand and uncensored. Individuals must be given assurances that neither the investigator nor the interpreter will misuse information in any way (see chapter VI, sect. C.2).

151. When the interpreter is not a professional, there is always the risk of the investigator losing control of the interview. Individuals may be carried away talking to the person who speaks their language, and the interview may divert from the issues at hand. There is also a risk that an interpreter with a bias might lead the interviewee on or distort the replies. Loss of information, sometimes relevant, sometimes not, is inevitable when working through interpretation. In extreme cases, it may even be necessary for investigators to refrain from taking notes during interviews and carry out interviews in several short sessions,

so as to have time to write down the main points of what has been said between sessions.

152. Investigators should remember to talk to the person and to maintain eye contact, even if he or she has a natural tendency to speak to the interpreter. It helps to use the second person when speaking through the interpreter, for example "what did you do next", rather than the third person "ask him what happened next". All too often, investigators write their notes during the time when the interpreter is either translating the question or the interviewee answering it. Some investigators do not appear to be listening, as the interview is going on in a language they do not understand. This should not be the case, as it is essential for investigators to observe not just the words but also the body language, facial expressions, tone of voice and gestures of the interviewee if they are to obtain a full picture. Investigators should familiarize themselves with torture-related words in the person's language so as to show that they know about the issue. Reacting, rather than showing a blank face, when hearing a torture-related word such as *submarino* or *darmashakra* will add to the investigator's credibility.

153. When visiting prisoners, it is best never to use local interpreters if there is a possibility of their being considered untrustworthy by those interviewed. It may also be unfair for the local interpreters, who may be "debriefed" by the local authorities after a visit, or otherwise put under pressure, to be involved with political prisoners. It is best to use independent interpreters, clearly seen as coming from elsewhere. The next best thing to speaking the local language fluently is to work with a trained interpreter with experience, who is sensitive to the issue of torture and to the local culture. As a rule, co-detainees should not be used for interpretation, unless it is obvious that the interviewee has chosen someone he or she trusts. In the case of people who are not in detention, many of these same rules also apply, but it may be easier to bring in someone (a local person) from the outside, which is rarely possible in prison situations.

### **J. Gender issues**

154. Ideally, an investigation team should contain specialists of both genders, permitting the person who says that they have been tortured to choose the gender of the investigator and, where necessary, the interpreter. This is particularly important when a woman has been detained in a situation where rape is known to happen, even if she has not, so far, complained of it. Even if no sexual assault takes place, most torture has sexual aspects (see chapter V, sect. D.8). The re-traumatization can often be worse if she feels she has to describe what happened to a person who is physically similar to her torturers, who will inevitably have been mostly or entirely men. In some cultures, it would be impossible for a male investigator to question a female victim, and this must be respected. However, in most cultures, if there is only a male physician available, many women would prefer to talk to him rather than a female of another profession in order to gain the medical information and advice that she wants. In such a case, it is essential that the interpreter, if used, be female. Some interviewees may also prefer that the interpreter be from

outside their immediate locality, both because of the danger of being reminded of their torture and because of the perceived threat to their confidentiality (see chapter IV, sect. I). If no interpreter is necessary, then a female member of the investigating team should be present as a chaperone throughout at least the physical examination and, if the patient wishes, throughout the entire interview.

155. When the victim is male and has been sexually abused, the situation is more complex because he too will have been sexually abused mostly or entirely by men. Some men would, therefore, prefer to describe their experiences to women because their fear of other men is so great, while others would not want to discuss such personal matters in front of a woman.

#### **K. Indications for referral**

156. Wherever possible, examinations to document torture for medical-legal reasons should be combined with an assessment for other needs, whether referral to specialist physicians, psychologists, physiotherapists or those who can offer social advice and support. Investigators should be aware of local rehabilitation and support services. The clinician should not hesitate to insist on any consultation and examination that he or she considers necessary in a medical evaluation. In the course of documenting medical evidence of torture and ill-treatment, physicians are not absolved of their ethical obligations. Those who appear to be in need of further medical or psychological care should be referred to the appropriate services.

#### **L. Interpretation of findings and conclusions**

157. Physical manifestations of torture may vary according to the intensity, frequency and duration of

abuse, the torture survivor's ability to protect him or herself and the physical condition of the detainee prior to the torture. Other forms of torture may not produce physical findings, but may be associated with other conditions. For example, beatings to the head that result in loss of consciousness can cause post-traumatic epilepsy or organic brain dysfunction. Also, poor diet and hygiene in detention can cause vitamin deficiency syndromes.

158. Certain forms of torture are strongly associated with particular sequelae. For example, beatings to the head that result in loss of consciousness are particularly important to the clinical diagnosis of organic brain dysfunction. Trauma to the genitals is often associated with subsequent sexual dysfunction.

159. It is important to realize that torturers may attempt to conceal their acts. To avoid physical evidence of beating, torture is often performed with wide, blunt objects, and torture victims are sometimes covered with a rug, or shoes in the case of *falanga*, to distribute the force of individual blows. Stretching, crushing injuries and asphyxiation are also forms of torture with the intention of producing maximal pain and suffering with minimal evidence. For the same reason, wet towels are used with electric shocks.

160. The report must list the qualifications and experience of the investigator. Where possible, the name of the witness or patient should be given. If this puts the person at significant risk, an identifier can be used that allows the investigating team to relate the person to the record, but that will not allow anyone else to identify the individual. The report must indicate who else was in the room at the time of the interview or any part of it. It should detail the relevant history, avoiding hearsay and, where appropriate, report the findings. It must be signed, dated and include any necessary declaration required by the jurisdiction for which it is written (see annex IV).

## CHAPTER V

## PHYSICAL EVIDENCE OF TORTURE

161. Witness and survivor testimony are necessary components in the documentation of torture. To the extent that physical evidence of torture exists, it provides important confirmatory evidence that a person has been tortured. However, the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars.

162. A medical evaluation for legal purposes should be conducted with objectivity and impartiality. The evaluation should be based on the physician's clinical expertise and professional experience. The ethical obligation of beneficence demands uncompromising accuracy and impartiality in order to establish and maintain professional credibility. When possible, clinicians who conduct evaluations of detainees should have specific essential training in forensic documentation of torture and other forms of physical and psychological abuse. They should have knowledge of prison conditions and torture methods used in the particular region where the patient was imprisoned and the common after-effects of torture. The medical report should be factual and carefully worded. Jargon should be avoided. All medical terminology should be defined so that it is understandable to lay persons. The physician should not assume that the official requesting a medical-legal evaluation has related all the material facts. It is the physician's responsibility to discover and report upon any material findings that he or she considers relevant, even if they may be considered irrelevant or adverse to the case of the party requesting the medical examination. Findings that are consistent with torture or other forms of ill-treatment must not be excluded from a medical-legal report under any circumstance.

#### A. Interview structure

163. These comments apply especially to interviews conducted with persons no longer in custody. The location of the interview and examination should be as safe and comfortable as possible. Sufficient time should be allotted to conduct a detailed interview and examination. A two-to-four-hour interview may be insufficient to conduct an evaluation for physical or psychological evidence of torture. Furthermore, at any given time of an evaluation, situation-specific variables, such as the dynamics of the interview, a patient's feelings of powerlessness in the face of having his/her intimacy intruded upon, fear of future persecution, shame about events and survivor guilt may simulate the circumstances of a torture experience. This may increase the patient's anxiety and resistance to disclose relevant information. A second, and possibly a third,

interview may have to be scheduled to complete the evaluation.

164. Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of someone who has experienced torture or other forms of abuse requires active listening, meticulous communication, courtesy and genuine empathy and honesty. Physicians must have the capacity to create a climate of trust in which disclosure of crucial, though perhaps very painful or shameful, facts can occur. It is important to be aware that those facts are sometimes intimate secrets that the person may reveal at that moment for the first time. In addition to providing a comfortable setting, adequate time for the interviews, refreshments and access to toilet facilities, the clinician should explain what the patient can expect in the evaluation. The clinician should be mindful of the tone, phrasing and sequencing of questions (sensitive questions should be asked only after some degree of rapport has been developed) and should acknowledge the patient's ability to take a break if needed or to choose not to respond to any question.

165. Physicians and interpreters have a duty to maintain confidentiality of information and to disclose information only with the patient's consent (see chapter III, sect. C). Each person should be examined individually with privacy. He or she should be informed of any limits on the confidentiality of the evaluation that may be imposed by State or judicial authorities. The purpose of the interview needs to be made clear to the person. Physicians must ensure that informed consent is based on adequate disclosure and understanding of the potential benefits and adverse consequences of a medical evaluation and that consent is given voluntarily without coercion by others, particularly law enforcement or judicial authorities. The person has the right to refuse the evaluation. In such circumstances, the clinician should document the reason for refusal of an evaluation. Furthermore, if the person is a detainee, the report should be signed by his or her lawyer and another health official.

166. Patients may fear that information revealed in the context of an evaluation may not be safely kept from being accessed by persecuting governments. Fear and mistrust may be particularly strong in cases where physicians or other health workers were participants in the torture. In many circumstances, the evaluator will be a member of the majority culture and ethnicity, whereas the patient, in the situation and location of the interview, is likely to belong to a minority group or culture. This dynamic of inequality may reinforce the perceived and real imbalance of power and may increase the potential



sense of fear, mistrust and forced submission in the patient.

167. Empathy and human contact may be the most important thing that people still in custody receive from the investigator. The investigation itself may contribute nothing of specific benefit to the person being interviewed, as in most cases their torture will be over. The meagre consolation of knowing that the information may serve a future purpose will however be greatly enhanced if the investigator shows appropriate empathy. While this may seem self-evident, all too often investigators in prison visits are so concerned about obtaining information that they fail to empathize with the prisoner being interviewed.

## **B. Medical history**

168. Obtain a complete medical history, including information about prior medical, surgical or psychiatric problems. Be sure to document any history of injuries before the period of detention and any possible after-effects. Avoid leading questions. Structure inquiries to elicit an open-ended, chronological account of the events experienced during detention.

169. Specific historical information may be useful in correlating regional practices of torture with individual allegations of abuse. Examples of useful information include descriptions of torture devices, body positions, methods of restraint, descriptions of acute or chronic wounds and disabilities and identifying information about perpetrators and places of detention. While it is essential to obtain accurate information regarding a torture survivor's experiences, open-ended interviewing methods require that patients should disclose these experiences in their own words using free recall. An individual who has survived torture may have trouble expressing in words his or her experiences and symptoms. In some cases, it may be helpful to use these trauma event and symptom checklists or questionnaires. If the interviewer believes it may be helpful to use these, there are numerous questionnaires available; however, none are specific to torture victims. All complaints made by a torture survivor are significant. Although there may be no correlation with the physical findings, they should be reported. Acute and chronic symptoms and disabilities associated with specific forms of abuse and the subsequent healing processes should be documented.

### *1. Acute symptoms*

170. The individual should be asked to describe any injuries that may have resulted from the specific methods of alleged abuse. These can be, for example, bleeding, bruising, swelling, open wounds, lacerations, fractures, dislocations, joint stress, haemoptysis, pneumothorax, tympanic membrane perforation, genito-urinary system injuries, burns (colour, bulla or necrosis according to the degree of burn), electrical injuries (size and number of lesions, their colour and surface characteristics), chemical injuries (colour, signs of necrosis), pain, numbness, constipation and vomiting. The intensity, frequency and duration of each symptom should be noted. The development of any subsequent skin lesions should be described indi-

cating whether or not they left scars. Ask about health on release; was he or she able to walk or confined to bed? If confined, for how long? How long did wounds take to heal? Were they infected? What treatment was received? Was it a physician or a traditional healer? Be aware that the detainee's ability to make such observations may have been compromised by the torture itself or its after-effects and should be documented.

### *2. Chronic symptoms*

171. Elicit information on physical ailments that the individual believes were associated with torture or ill-treatment. Note the severity, frequency and duration of each symptom and any associated disability or need for medical or psychological care. Even if the after-effects of acute lesions cannot be seen months or years later, some physical findings may still remain, such as electrical current or thermal burn scars, skeletal deformities, incorrect healing of fractures, dental injuries, loss of hair and myofibrosis. Common somatic complaints include headache, back pain, gastrointestinal symptoms, sexual dysfunction and muscle pain. Common psychological symptoms include depressive affect, anxiety, insomnia, nightmares, flashbacks and memory difficulties (see chapter VI, sect. B.2).

### *3. Summary of an interview*

172. Torture victims may have injuries that are substantially different from other forms of trauma. Although acute lesions may be characteristic of the alleged injuries, most lesions heal within about six weeks of torture, leaving no scars or, at the most, non-specific scars. This is often the case when torturers use techniques that prevent or limit detectable signs of injury. Under such circumstances, the physical examination may be within normal limits, but this in no way negates allegations of torture. A detailed account of the patient's observations of acute lesions and the subsequent healing process often represents an important source of evidence in corroborating specific allegations of torture or ill-treatment.

## **C. The physical examination**

173. Subsequent to the acquisition of background information and after the patient's informed consent has been obtained, a complete physical examination by a qualified physician should be performed. Whenever possible, the patient should be able to choose the gender of the physician and, where used, of the interpreter. If the doctor is not of the same gender as the patient, a chaperone who is should be used unless the patient objects. The patient must understand that he or she is in control and has the right to limit the examination or to stop it at any time (see chapter IV, sect. J).

174. In this section, there are many references to specialist referral and further investigations. Unless the patient is in detention, it is important for physicians to have access to physical and psychological treatment facilities, so that any identified need can be followed up. In many situations, certain diagnostic test techniques will

not be available, and their absence must not invalidate the report (see annex II for further details of possible diagnostic tests).

175. In cases of alleged recent torture and when the clothes worn during torture are still being worn by the torture survivor, they should be taken for examination without having been washed, and a fresh set of clothes should be provided. Wherever possible, the examination room should be equipped with sufficient light and medical equipment for the examination. Any deficiencies should be noted in the report. The examiner should note all pertinent positive and negative findings, using body diagrams to record the location and nature of all injuries (see annex III). Some forms of torture such as electrical shock or blunt trauma may be initially undetectable, but may be detected during a follow-up examination. Although it will rarely be possible to record photographically lesions of prisoners in custody of their torturers, photography should be a routine part of examinations. If a camera is available, it is always better to take poor quality photographs than to have none. They should be followed up with professional photographs as soon as possible (see chapter III, sect. C.5).

## 1. Skin

176. The examination should include the entire body surface in order to detect signs of generalized skin disease including signs of vitamin A, B and C deficiency, pre-torture lesions or lesions inflicted by torture, such as abrasions, contusions, lacerations, puncture wounds, burns from cigarettes or heated instruments, electrical injuries, alopecia and nail removal. Torture lesions should be described by their localization, symmetry, shape, size, colour and surface (e.g. scaly, crusty, ulcerating) as well as their demarcation and level in relation to the surrounding skin. Photography is essential whenever possible. Ultimately, the examiner must offer an opinion as to the origin of the lesions: inflicted or self-inflicted, accidental or the result of a disease process.<sup>73, 74</sup>

## 2. Face

177. Facial tissues should be palpated for evidence of fracture, crepitation, swelling or pain. The motor and sensory components, including smell and taste of all cranial nerves, should be examined. Computerized tomography (CT), rather than routine radiography, is the best modality to diagnose and characterize facial fractures, determine alignment and diagnose associated soft tissue injuries and complications. Intracranial and cervical spinal injuries are often associated with facial trauma.

<sup>73</sup> O. V. Rasmussen, "Medical aspects of torture", *Danish Medical Bulletin*, vol. 37, supplement No. 1 (1990), pp. 1-88.

<sup>74</sup> R. Bunting, "Clinical examinations in the police context", *Clinical Forensic Medicine*, W. D. S. McLay, ed. (London, Greenwich Medical Media, 1996), pp. 59-73.

## (a) Eyes

178. There are many forms of trauma to the eyes, including conjunctival haemorrhage, lens dislocation, subhyeloid haemorrhage, retrobulbar haemorrhage, retinal haemorrhage and visual field loss. Given the serious consequences of lack of treatment or improper treatment, ophthalmologic consultation should be obtained whenever there is a suspicion of ocular trauma or disease. CT is the best modality to diagnose orbital fractures and soft tissue injuries to the bulbar and retrobulbar contents. Nuclear magnetic resonance imaging (MRI) may be an adjunct for identifying soft tissue injury. High resolution ultrasound is an alternative method for evaluation of trauma to the eye globe.

## (b) Ears

179. Trauma to the ears, especially rupture of the tympanic membrane, is a frequent consequence of harsh beatings. The ear canals and tympanic membranes should be examined with an otoscope and injuries described. A common form of torture, known in Latin America as *telefono*, is a hard slap of the palm to one or both ears, rapidly increasing pressure in the ear canal, thus rupturing the drum. Prompt examination is necessary to detect tympanic membrane ruptures less than 2 millimetres in diameter, which may heal within 10 days. Fluid may be observed in the middle or external ear. If otorrhea is confirmed by laboratory analysis, MRI or CT should be performed to determine the fracture site. The presence of hearing loss should be investigated, using simple screening methods. If necessary, audiometric tests should be conducted by a qualified audiometric technician. The radiographic examination of fractures of the temporal bone or disruption of the ossicular chain is best determined by CT, then hypocycloidal tomography and, lastly, linear tomography.

## (c) Nose

180. The nose should be evaluated for alignment, crepitation and deviation of the nasal septum. For simple nasal fractures, standard nasal radiographs should be sufficient. For complex nasal fractures and when the cartilaginous septum is displaced, CT should be performed. If rhinorrhea is present, CT or MRI is recommended.

## (d) Jaw, oropharynx and neck

181. Mandibular fractures or dislocations may result from beatings. Temporomandibular joint syndrome is a frequent consequence of beatings about the lower face and jaw. The patient should be examined for evidence of crepitation of the hyoid bone or laryngeal cartilage resulting from blows to the neck. Findings concerning the oropharynx should be noted in detail, including lesions consistent with burns from electrical shock or other trauma. Gingival haemorrhage and the condition of the gums should also be noted.

## (e) Oral cavity and teeth

182. Examination by a dentist should be considered a component of periodic health examination in detention. This examination is often neglected, but it is an important

component of the physical examination. Dental care may be purposefully withheld to allow caries, gingivitis or tooth abscesses to worsen. A careful dental history should be taken, and, if dental records exist, they should be requested. Tooth avulsions, fractures of the teeth, dislocated fillings and broken prostheses may result from direct trauma or electric shock torture. Dental caries and gingivitis should be noted. Poor quality dentition may be due to conditions in detention or may have preceded the detention. The oral cavity must be carefully examined. During application of an electric current, the tongue, gums or lips may be bitten. Lesions might be produced by forcing objects or materials into the mouth, as well as by applying electric current. X-rays and MRI are able to determine the extent of soft tissue, mandibular and dental trauma.

### 3. *Chest and abdomen*

183. Examination of the trunk, in addition to noting lesions of the skin, should be directed towards detecting regions of pain, tenderness or discomfort that would reflect underlying injuries of the musculature, ribs or abdominal organs. The examiner must consider the possibility of intramuscular, retroperitoneal and intra-abdominal haematomas, as well as laceration or rupture of an internal organ. Ultrasonography, CT and bone scintigraphy should be used, when realistically available, to confirm such injuries. Routine examination of the cardiovascular system, lungs and abdomen should be performed in the usual manner. Pre-existing respiratory disorders are likely to be aggravated in custody, and new respiratory disorders frequently develop.

### 4. *Musculoskeletal system*

184. Complaints of musculoskeletal aches and pains are very common in survivors of torture.<sup>75</sup> They may be the result of repeated beatings, suspension, other positional torture or the general physical environment of detention.<sup>76</sup> They may also be somatic (see chapter VI, sect. B.2). While they are non-specific, they should be documented. They often respond well to sympathetic physiotherapy.<sup>77</sup> Physical examination of the skeleton should include testing for mobility of joints, the spine and the extremities. Pain with motion, contracture, strength, evidence of compartment syndrome, fractures with or without deformity and dislocations should all be noted. Suspected dislocations, fractures and osteomyelitis should be evaluated with radiographs. For suspected osteomyelitis, routine radiographs should be taken, followed by three-phase bone scintigraphy. Injuries to tendons, ligaments and muscles are best evaluated with MRI, but arthrography can also be performed. In the acute stage, this can detect haemorrhage and possible muscle tears. Muscles usually heal completely without scarring; thus, later imaging studies will be negative. Under MRI and CT, denervated muscles and chronic compartment

syndrome will be imaged as muscle fibrosis. Bone bruises can be detected by MRI or scintigraphy. Bone bruises usually heal without leaving traces.

### 5. *Genito-urinary system*

185. Genital examination should be performed only with the consent of the patient and, if necessary, should be postponed to a later examination. A chaperone must be present if the examining physician's gender is different from that of the patient. For more information, see chapter IV, sect. J. See section D.8 below for further information regarding examination of victims of sexual assault. Ultrasonography and dynamic scintigraphy can be used for detecting genito-urinary trauma.

### 6. *Central and peripheral nervous systems*

186. The neurological examination should evaluate the cranial nerves, sensory organs and peripheral nervous system, checking for both motor and sensory neuropathies related to possible trauma, vitamin deficiencies or disease. Cognitive ability and mental status must also be evaluated (see chapter VI, sect. C). In patients who report being suspended, special emphasis on examination for brachial plexopathy (asymmetrical hand strength, wrist drop, arm weakness with variable sensory and tendon reflexes) is necessary. Radiculopathies, other neuropathies, cranial nerve deficits, hyperalgesia, parasthesias, hyperaesthesia, change in position, temperature sensation, motor function, gait and coordination may all result from trauma associated with torture. In patients with a history of dizziness and vomiting, a vestibular examination should be conducted, and evidence of nystagmus noted. Radiological evaluation should include MRI or CT. MRI is preferred over CT for radiological evaluation of the brain and posterior fossae.

## **D. Examination and evaluation following specific forms of torture**

187. The following discussion is not meant to be an exhaustive discussion of all forms of torture, but it is intended to describe in more detail the medical aspects of many of the more common forms of torture. For each lesion and for the overall pattern of lesions, the physician should indicate the degree of consistency between it and the attribution given by the patient. The following terms are generally used:

(a) Not consistent: the lesion could not have been caused by the trauma described;

(b) Consistent with: the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes;

(c) Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes;

(d) Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes;

<sup>75</sup> See footnote 73 above.

<sup>76</sup> D. Forrest, "Examination for the late physical after-effects of torture", *Journal of Clinical Forensic Medicine*, vol. 6 (1999), pp. 4-13.

<sup>77</sup> See footnote 73 above.

(e) Diagnostic of: this appearance could not have been caused in any way other than that described.

188. Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story (see chapter IV, sect. G, for a list of torture methods).

### 1. *Beatings and other forms of blunt trauma*

#### (a) *Skin damage*

189. Acute lesions are often characteristic of torture, because they show a pattern of inflicted injury that differs from non-inflicted injuries, for example, their shape, repetition, distribution on the body. Since most lesions heal within about six weeks of torture, leaving no scars or non-specific scars, a characteristic history of the acute lesions and their development until healing might be the only support for an allegation of torture. Permanent changes in the skin due to blunt trauma are infrequent, non-specific and usually without diagnostic significance. A sequel of blunt violence, which is diagnostic of prolonged application of tight ligatures, is a linear zone extending circularly around the arm or leg, usually at the wrist or ankle. This zone contains few hairs or hair follicles, and this is probably a form of cicatricial alopecia. No differential diagnosis in the form of a spontaneous skin disease exists, and it is difficult to imagine any trauma of this nature occurring in everyday life.

190. Among acute lesions, abrasions resulting from superficial scraping lesions of the skin may appear as scratches, brush-burn type lesions or larger scraped lesions. At times, abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. Repeated or deep abrasions may create areas of hypo or hyperpigmentation, depending on skin type. This occurs on the inside of the wrists if the hands have been tied together tightly.

191. Contusions and bruises are areas of haemorrhage into soft tissue due to the rupture of blood vessels from blunt trauma. The extent and severity of a contusion depend not only on the amount of force applied but also on the structure and vascularity of the contused tissue. Contusions occur more readily in areas of thin skin overlying bone or in fatty areas. Many medical conditions, including vitamin and other nutritional deficiencies, may be associated with easy bruising or purpura. Contusions and abrasions indicate that blunt force has been applied to a particular area. The absence of a bruise or abrasion, however, does not indicate that there was no blunt force to that area. Contusions may be patterned, reflecting the contours of the inflicting instrument. For instance, rail-shaped bruising may occur when an instrument, such as a truncheon or cane, has been used. The shape of the object may be inferred from the shape of the bruise. As contusions resolve, they undergo a series of colour changes. Most bruises initially appear dark blue, purple or crimson. As the haemoglobin in the bruise breaks down, the colour gradually changes to violet, green, dark yellow or pale yellow and then disappears. It is very difficult, however, to date accurately the occurrence of contusions. In some

skin types, this can lead to hyperpigmentation, which can last several years. Contusions that develop in deeper subcutaneous tissues may not appear until several days after injury, when the extravasated blood has reached the surface. In cases of an allegation but an absence of a contusion, the victim should be re-examined after several days. It should be taken into consideration that the final position and shape of bruises bear no relationship to the original trauma and that some lesions may have faded by the time of re-examination.<sup>78</sup>

192. Lacerations, a tearing or crushing of the skin and underlying soft tissues by the pressure of blunt force, develop easily on the protruding parts of the body, since the skin is compressed between the blunt object and the bone surface under the subdermal tissues. However, with sufficient force the skin can be torn on any part of the body. Asymmetrical scars, scars in unusual locations and a diffuse spread of scarring all suggest deliberate injury.<sup>79</sup>

193. Scars resulting from whipping represent healed lacerations. These scars are depigmented and often hypertrophic, surrounded by narrow, hyperpigmented stripes. The only differential diagnosis is plant dermatitis, but this is dominated by hyperpigmentation and shorter scars. By contrast, symmetrical, atrophic, depigmented linear changes of the abdomen, axillae and legs, which are sometimes claimed to be torture sequelae, represent striae distensae and are not normally related to torture.<sup>80</sup>

194. Burning is the form of torture that most frequently leaves permanent changes in the skin. Sometimes, these changes may be of diagnostic value. Cigarette burns often leave 5-10-millimetre-long, circular or ovoid, macular scars with a hyper or a hypopigmented centre and a hyperpigmented, relatively indistinct periphery. The burning away of tattoos with cigarettes has also been reported in relation to torture. The characteristic shape of the resulting scar and any tattoo remnants will help in the diagnosis.<sup>81</sup> Burning with hot objects produces markedly atrophic scars which reflect the shape of the instrument and which are sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones corresponding to an initial zone of inflammation. This may, for instance, be seen after burning with an electrically heated metal rod or a gas lighter. It is difficult to make a differential diagnosis if many scars are present. Spontaneously occurring inflammatory processes lack the characteristic marginal zone and only rarely show a pronounced loss of tissue. Burning may result in hypertrophic or keloid scars as is the case following a burn produced by burning rubber.

195. When the nail matrix is burnt, subsequent growth produces striped, thin, deformed nails, sometimes broken up in longitudinal segments. If a nail has been pulled off, an overgrowth of tissue may be produced from

<sup>78</sup> S. Gürpınar and S. Korur Fincancı, "İnsan Hakları İhlalleri ve Hekim Sorumluluğu" (Human rights violations and responsibility of the physician), *Birinci Basamak İçin Adli Tıp El Kitabı* (Handbook of Forensic Medicine for General Practitioners) (Ankara, Turkish Medical Association, 1999).

<sup>79</sup> See footnote 73 above.

<sup>80</sup> L. Danielsen, "Skin changes after torture", *Torture*, vol. 2, supplement 1 (1992), pp. 27-28.

<sup>81</sup> Ibid.

the proximal nail fold, resulting in the formation of pterygium. Changes in the nail caused by *Lichen planus* constitute the only relevant differential diagnosis, but they will usually be accompanied by widespread skin injury. On the other hand, fungus infections are characterized by thickened, yellowish, crumbling nails, different from the above changes.

196. Sharp trauma wounds are produced when the skin is cut with a sharp object, such as a knife, bayonet or broken glass and include stab wounds, incised or cut wounds and puncture wounds. The acute appearance is usually easy to distinguish from the irregular and torn appearance of lacerations and scars found upon later examination that may be distinctive. Regular patterns of small incisional scars could be due to traditional healers.<sup>82</sup> If pepper or other noxious substances are applied to open wounds, the scars may become hypertrophic. An asymmetrical pattern and different sizes of scars are probably significant in the diagnosis of torture.

#### (b) *Fractures*

197. Fractures produce a loss of bone integrity due to the effect of a blunt mechanical force on various vector planes. A direct fracture occurs at the site of impact or at the site where the force was applied. The location, contour and other characteristics of a fracture reflect the nature and direction of the applied force. It is sometimes possible to distinguish fracture inflicted from accidental injury by the radiological appearance of the fracture. Radiographic dating of relatively recent fractures should be done by an experienced trauma radiologist. Speculative judgements should be avoided in the evaluations of the nature and age of blunt traumatic lesions, since a lesion may vary according to the age, sex, tissue characteristics, the condition and health of the patient and the severity of the trauma. For example, well-conditioned, muscularly fit, younger individuals are more resistant to bruising than frail, older individuals.

#### (c) *Head trauma*

198. Head trauma is one of the most common forms of torture. In cases of recurring head trauma, even if not always of serious dimensions, cortical atrophy and diffuse axonal damage can be expected. In cases of trauma caused by falls, counterpunch (location in opposition to the trauma) lesions of the brain may be observed. Whereas in cases of direct trauma, contusions of the brain may be observed directly under the region in which the trauma is inflicted. Scalp bruises are frequently invisible externally unless there is swelling. Bruises may be difficult to see in dark-skinned individuals, but will be tender upon palpation.

199. Having been exposed to blows to the head, a torture survivor may complain of continuous headaches. These are often somatic or may be referred from the neck (see section C above). The victim may claim to suffer pain when touched in that region, and diffuse or local fullness or increased firmness may be observed by means of palpation of the scalp. Scars can be observed in cases where there have been lacerations of the scalp. Headaches may

be the initial symptom of an expanding subdural haematoma. They may be associated with the acute onset of mental status changes, and a CT scan must be performed urgently. Soft tissue swelling or haemorrhage will usually be detected with CT or MRI. It may also be appropriate to arrange psychological or neuropsychological assessment (see chapter VI, sect. C.4).

200. Violent shaking as a form of torture may produce cerebral injury without leaving any external marks, although bruises may be present on the upper chest or shoulders where the victim or his clothing has been grabbed. At its most extreme, shaking can produce injuries identical to those seen in the shaken baby syndrome: cerebral oedema, subdural haematoma and retinal haemorrhages. More commonly, victims complain of recurrent headaches, disorientation or mental status changes. Shaking episodes are usually brief, only a few minutes or less, but may be repeated many times over a period of days or weeks.

#### (d) *Chest and abdominal trauma*

201. Rib fractures are a frequent consequence of beatings to the chest. If displaced, they can be associated with lacerations of the lung and possible pneumothorax. Fractures of the vertebral pedicles may result from direct use of blunt force.

202. In cases of acute abdominal trauma, the physical examination should seek evidence of abdominal organ and urinary tract injury. However, the examination is often negative. Gross haematuria is the most significant indication of kidney contusion. Peritoneal lavage may detect occult abdominal haemorrhage. Free abdominal fluid detected by CT after peritoneal lavage may be from the lavage or haemorrhage; thus invalidating the finding. On a CT, acute abdominal haemorrhage is usually isointense or reveals water density unlike acute central nervous system (CNS) haemorrhage, which is hyperintense. Organ injury may be present as free air, extraluminal fluid or areas of low attenuation, which may represent oedema, contusion, haemorrhage or a laceration. Peripancreatic oedema is one of the signs of acute traumatic and non-traumatic pancreatitis. Ultrasound is particularly useful in detecting subcapsular haematomas of the spleen. Renal failure due to crush syndrome may be acute after severe beatings. Renal hypertension can be a late complication of renal injury.

### 2. *Beatings to the feet*

203. *Falanga* is the most common term for repeated application of blunt trauma to the feet (or more rarely to the hands or hips), usually applied with a truncheon, a length of pipe or similar weapon. The most severe complication of *falanga* is closed compartment syndrome, which can cause muscle necrosis, vascular obstruction or gangrene of the distal portion of the foot or toes. Permanent deformities of the feet are uncommon but do occur, as do fractures of the carpal, metacarpal and phalanges. Because the injuries are usually confined to soft tissue, CT or MRI are the preferred methods for radiological documentation of the injury, but it must be emphasized that physical examination in the acute phase should be

<sup>82</sup> See footnote 76 above.

diagnostic. *Falanga* may produce chronic disability. Walking may be painful and difficult. The tarsal bones may be fixed (spastic) or have increased motion. Squeezing the plantar (sole) of the foot and dorsiflexion of the great toe may produce pain. On palpation, the entire length of the plantar aponeurosis may be tender and the distal attachments of the aponeurosis may be torn, partly at the base of the proximal phalanges, partly at the skin. The aponeurosis will not tighten normally, making walking difficult and muscle fatigue may follow. Passive extension of the big toe may reveal whether the aponeurosis has been torn. If it is intact, the beginning of tension in the aponeurosis should be felt on palpation when the toe is dorsiflexed to 20 degrees; maximum normal extension is about 70 degrees. Higher values suggest injury to the attachments of the aponeurosis.<sup>83, 84, 85, 86</sup> On the other hand, limited dorsiflexion and pain on hyperextension of the large toe are findings of *Hallux rigidus*, which results from dorsal osteophyte at the first metatarsal head and/or base of the proximal phalanx.

204. Numerous complications and syndromes can occur:

(a) Closed compartment syndrome. This is the most severe complication. An oedema in a closed compartment results in vascular obstruction and muscle necrosis, which may result in fibrosis, contracture or gangrene in the distal foot or toes. It is usually diagnosed by measuring pressures in the compartment;

(b) Crushed heel and anterior footpads. The elastic pads under the calcaneus and proximal phalanges are crushed during *falanga*, either directly or as a result of oedema associated with the trauma. Also, the connective tissue bands that extend through adipose tissue and connect bone to the skin are torn. Adipose tissue is deprived of its blood supply and atrophies. The cushioning effect is lost and the feet no longer absorb the stresses produced by walking;

(c) Rigid and irregular scars involving the skin and subcutaneous tissues of the foot after the application of *falanga*. In a normal foot, the dermal and sub-dermal tissues are connected to the planter aponeurosis through tight connective tissue bands. However, these bands can be partially or completely destroyed due to the oedema that ruptures the bands after exposure to *falanga*;

(d) Rupture of the plantar aponeurosis and tendons of the foot. An oedema in the post-*falanga* period may rupture these structures. When the supportive function necessary for the arch of the foot disappears, the act of walking becomes more difficult and foot muscles, especially the *quadratus plantaris longus*, are excessively forced;

(e) Planter fasciitis. May occur as a further complication of this injury. In cases of *falanga*, irritation is often present throughout the whole aponeurosis, causing chronic aponeurosis. Studies on the subject have shown that in prisoners released after 15 years of detention and who claimed to have been subjected to *falanga* application when first arrested, positive bone scans of hyperactive points in the calcaneus or metatarsal bones were observed.<sup>87</sup>

205. Radiological methods such as MRI, CT scan and ultrasound can often confirm cases of trauma occurring as a result of the application of *falanga*. Positive radiological findings may also be secondary to other diseases or trauma. Routine radiographs are recommended as the initial examination. MRI is the preferred radiological examination for detecting soft tissue injury. MRI or scintigraphy can detect bone injury in the form of a bruise, which may not be detected by routine radiographs or CT.<sup>88</sup>

### 3. Suspension

206. Suspension is a common form of torture that can produce extreme pain, but which leaves little, if any, visible evidence of injury. A person still in custody may be reluctant to admit to being tortured, but the finding of peripheral neurological deficits, diagnostic of brachial plexopathy, virtually proves the diagnosis of suspension torture. Suspension can be applied in various forms:

(a) Cross suspension. Applied by spreading the arms and tying them to a horizontal bar;

(b) Butchery suspension. Applied by fixation of hands upwards, either together or one by one;

(c) Reverse butchery suspension. Applied by fixation of feet upward and the head downward;

(d) "Palestinian" suspension. Applied by suspending the victim with the forearms bound together behind the back, the elbows flexed 90 degrees and the forearms tied to a horizontal bar. Alternatively, the prisoner is suspended from a ligature tied around the elbows or wrists with the arms behind the back;

(e) "Parrot perch" suspension. Applied by suspending a victim by the flexed knees from a bar passed below the popliteal region, usually while the wrists are tied to the ankles.

207. Suspension may last from 15 to 20 minutes to several hours. "Palestinian" suspension may produce permanent brachial plexus injury in a short period. The "parrot perch" may produce tears in the cruciate ligaments of the knees. Victims will often be beaten while suspended or otherwise abused. In the chronic phase, it is usual for pain and tenderness around the shoulder joints to persist,

<sup>83</sup> G. Sklyv, "Physical sequelae of torture", in *Torture and Its Consequences: Current Treatment Approaches*, M. Başoğlu, ed. (Cambridge, Cambridge University Press, 1992), pp. 38-55.

<sup>84</sup> See footnote 76.

<sup>85</sup> K. Prip, L. Tived, N. Holten, *Physiotherapy for Torture Survivors: A Basic Introduction* (Copenhagen, International Rehabilitation Council for Torture Victims, 1995).

<sup>86</sup> F. Bojsen-Møller and K. E. Flagstad, "Plantar aponeurosis and internal architecture of the ball of the foot", *Journal of Anatomy*, vol. 121 (1976), pp. 599-611.

<sup>87</sup> V. Lök and others, "Bone scintigraphy as clue to previous torture", *The Lancet*, vol. 337, No. 8745 (1991), pp. 846-847. See also M. Tunca and V. Lök, "Bone scintigraphy in screening of torture survivors", *The Lancet*, vol. 352, No. 9143 (1998), p. 1859.

<sup>88</sup> See footnotes 76 and 83 and V. Lök and others, "Bone scintigraphy as an evidence of previous torture", *Treatment and Rehabilitation Center Report of the Human Rights Foundation of Turkey* (Ankara, 1994), pp. 91-96.

as the lifting of weight and rotation, especially internal, will cause severe pain many years later. Complications in the acute period following suspension include weakness of the arms or hands, pain and paresthesias, numbness, insensitivity to touch, superficial pain and tendon reflex loss. Intense deep pain may mask muscle weakness. In the chronic phase, weakness may continue and progress to muscle wasting. Numbness and, more frequently, paresthesia are present. Raising the arms or lifting weight may cause pain, numbness or weakness. In addition to neurologic injury, there may be tears of the ligaments of the shoulder joints, dislocation of the scapula and muscle injury in the shoulder region. On visual inspection of the back, a "winged scapula" (prominent vertebral border of the scapula) may be observed with injury to the long thoracic nerve or dislocation of the scapula.

208. Neurologic injury is usually asymmetrical in the arms. Brachial plexus injury manifests itself in motor, sensory and reflex dysfunction.

(a) Motor examination. Asymmetrical muscle weakness, more prominent distally, is the most expected finding. Acute pain may make the examination for muscle strength difficult to interpret. If the injury is severe, muscle atrophy may be seen in the chronic phase;

(b) Sensory examination. Complete loss of sensation or paresthesias along the sensory nerve pathways is common. Positional perception, two-point discrimination, pinprick evaluation and perception of heat and cold should all be tested. If at least three weeks later, deficiency or reflex loss or decrease is present, appropriate electrophysiological studies should be performed by a neurologist experienced in the use and interpretation of these methodologies;

(c) Reflex examination. Reflex loss, a decrease in reflexes or a difference between the two extremities may be present. In "Palestinian" suspension, even though both brachial plexi are subjected to trauma, asymmetric plexopathy may develop due to the manner in which the torture victim has been suspended, depending on which arm is placed in a superior position or the method of binding. Although research suggests that brachial plexopathies are usually unilateral, that is at variance with experience in the context of torture, where bilateral injury is common.

209. Among the shoulder region tissues, the brachial plexus is the structure most sensitive to traction injury. "Palestinian" suspension creates brachial plexus damage due to forced posterior extension of the arms. As observed in the classical type of "Palestinian" suspension, when the body is suspended with the arms in posterior hyperextension, typically the lower plexus and then the middle and upper plexus fibres, if the force on the plexus is severe enough, are damaged, respectively. If the suspension is of a "crucifixion" type, but does not include hyperextension, the middle plexus fibres are likely to be the first ones damaged due to hyperabduction. Brachial plexus injuries may be categorized as follows:

(a) Damage to the lower plexus. Deficiencies are localized in the forearm and hand muscles. Sensory deficiencies may be observed on the forearm and at the fourth and fifth fingers of the hand's medial side in an ulnar nerve distribution;

(b) Damage to the middle plexus. Forearm, elbow and finger extensor muscles are affected. Pronation of the forearm and radial flexion of the hand may be weak. Sensory deficiency is found on the forearm and on the dorsal aspects of the first, second and third fingers of the hand in a radial nerve distribution. Triceps reflexes may be lost;

(c) Damage to the upper plexus. Shoulder muscles are especially affected. Abduction of the shoulder, axial rotation and forearm pronation-supination may be deficient. Sensory deficiency is noted in the deltoid region and may extend to the arm and outer parts of the forearm.

#### 4. *Other positional torture*

210. There are many forms of positional torture, all of which tie or restrain the victim in contorted, hyperextended or other unnatural positions, which cause severe pain and may produce injuries to ligaments, tendons, nerves and blood vessels. Characteristically, these forms of torture leave few, if any, external marks or radiological findings, despite subsequent frequently severe chronic disability.

211. All positional torture is directed towards tendons, joints and muscles. There are various methods: "parrot suspension", "banana stand" or the classic "banana tie" over a chair just on the ground, or on a motorcycle, forced standing, forced standing on a single foot, prolonged standing with arms and hands stretched high on a wall, prolonged forced squatting and forced immobilization in a small cage. In accordance with the characteristics of these positions, complaints are characterized as pain in a region of the body, limitation of joint movement, back pain, pain in the hands or cervical parts of the body and swelling of the lower legs. The same principles of neurologic and musculoskeletal examination apply to these forms of positional torture as apply to suspension. MRI is the preferred radiologic modality for evaluation of injuries associated with all forms of positional torture.

#### 5. *Electric shock torture*

212. Electric current is transmitted through electrodes placed on any part of the body. The most common areas are the hands, feet, fingers, toes, ears, nipples, mouth, lips and genital area. The power source may be a hand-cranked or combustion generator, wall source, stun gun, cattle prod or other electric device. Electric current follows the shortest route between the two electrodes. The symptoms that occur when electric current is applied have this characteristic. For example, if electrodes are placed on a toe of the right foot and on the genital region, there will be pain, muscle contraction and cramps in the right thigh and calf muscles. Excruciating pain will be felt in the genital region. Since all muscles along the route of the electric current are tetanically contracted, dislocation of the shoulder, lumbar and cervical radiculopathies may be observed when the current is moderately high. However, the type, time of application, current and voltage of the energy used cannot be determined with certainty upon physical examination of the victim. Torturers often use water or gels in order to increase the efficiency of the tor-

ture, expand the entrance point of the electric current on the body and prevent detectable electric burns. Trace electrical burns are usually a reddish brown circular lesion from 1 to 3 millimetres in diameter, usually without inflammation, which may result in a hyperpigmented scar. Skin surfaces must be carefully examined because the lesions are not often easily discernible. The decision to biopsy recent lesions to prove their origin is controversial. Electrical burns may produce specific histologic changes, but these are not always present, and the absence of change in no way mitigates against the lesion being an electrical burn. The decision must be made on a case-by-case basis as to whether or not the pain and discomfort associated with a skin biopsy can be justified by the potential results of the procedure (see annex II, sect. 2).

#### 6. *Dental torture*

213. Dental torture may be in the form of breaking or extracting teeth or through application of electrical current to the teeth. It may result in a loss or breaking of the teeth, swelling of the gums, bleeding, pain, gingivitis, stomatitis, mandibular fractures or loss of fillings from teeth. Temporomandibular joint syndrome will produce pain in the temporomandibular joint, limitation of jaw movement and, in some cases, subluxation of this joint due to muscle spasms occurring as a result of the electrical current or blows to the face.

#### 7. *Asphyxiation*

214. Near asphyxiation by suffocation is an increasingly common method of torture. It usually leaves no mark, and recuperation is rapid. This method of torture was so widely used in Latin America, that its name in Spanish, *submarino*, has become part of human rights vocabulary. Normal respiration might be prevented through such methods as covering the head with a plastic bag, closure of the mouth and nose, pressure or ligature around the neck or forced aspiration of dust, cement, hot peppers, etc. This is also known as "dry *submarino*". Various complications might develop, such as petechiae of the skin, nosebleeds, bleeding from the ears, congestion of the face, infections in the mouth and acute or chronic respiratory problems. Forcible immersion of the head in water, often contaminated with urine, faeces, vomit or other impurities, may result in near drowning or drowning. Aspiration of the water into the lungs may lead to pneumonia. This form of torture is called "wet *submarino*". In hanging or in other ligature asphyxiation, patterned abrasions or contusions can often be found on the neck. The hyoid bone and laryngeal cartilage may be fractured by partial strangulation or from blows to the neck.

#### 8. *Sexual torture including rape*

215. Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations. An individual is never as vulnerable as when naked and helpless. Nudity enhances the psychological terror of every aspect of torture, as there is always the background of potential abuse, rape or sodomy. Furthermore, verbal sexual threats, abuse and mocking are also part of sexual torture, as they enhance the humiliation and its degrading

aspects, all part and parcel of the procedure. The groping of women is traumatic in all cases and is considered to be torture.

216. There are some differences between sexual torture of men and sexual torture of women, but several issues apply to both. Rape is always associated with the risk of developing sexually transmitted diseases, particularly human immunodeficiency virus (HIV).<sup>89</sup> Currently, the only effective prophylaxis against HIV must be taken within hours of the incident, and it is not generally available in countries where torture occurs routinely. In most cases, there will be a lewd sexual component, and in other cases torture is targeted at the genitals. Electricity and blows are generally targeted on the genitals in men, with or without additional anal torture. The resulting physical trauma is enhanced by verbal abuse. There are often threats of loss of masculinity to men and consequent loss of respect in society. Prisoners may be placed naked in cells with family members, friends or total strangers, breaking cultural taboos. This can be made worse by the absence of privacy when using toilet facilities. Additionally, prisoners may be forced to abuse each other sexually, which can be particularly difficult to cope with emotionally. The fear of potential rape among women, given profound cultural stigma associated with rape, can add to the trauma. Not to be neglected are the trauma of potential pregnancy, which males, obviously, do not experience, the fear of losing virginity and the fear of not being able to have children (even if the rape can be hidden from a potential husband and the rest of society).

217. If in cases of sexual abuse the victim does not wish the event to be known due to sociocultural pressures or personal reasons, the physician who carries out the medical examination, investigative agencies and the courts have an obligation to cooperate in maintaining the victim's privacy. Establishing a rapport with torture survivors who have recently been sexually assaulted requires special psychological education and appropriate psychological support. Any treatment that would increase the psychological trauma of a torture survivor should be avoided. Before starting the examination, permission must be obtained from the individual for any kind of examination, and this should be confirmed by the victim before the more intimate parts of the examination. The individual should be informed about the importance of the examination and its possible findings in a clear and comprehensible manner.

#### (a) *Review of symptoms*

218. A thorough history of the alleged assault should be recorded as described earlier in this manual (see section B above). There are, however, some specific questions that are relevant only to an allegation of sexual abuse. These seek to elicit current symptoms resulting from a recent assault, for example bleeding, vaginal or anal discharge and location of pain, bruises or sores. In cases of sexual assault in the past, questions should be directed to ongoing symptoms that resulted from the

<sup>89</sup> I. Lunde and J. Ortmann, "Sexual torture and the treatment of its consequences", *Torture and Its Consequences, Current Treatment Approaches*, M. Başoğlu, ed. (Cambridge, Cambridge University Press, 1992), pp. 310-331.



assault, such as urinary frequency, incontinence or dysuria, irregularity of menstruation, subsequent history of pregnancy, abortion or vaginal haemorrhage, problems with sexual activity, including intercourse and anal pain, bleeding, constipation or incontinence.

219. Ideally, there should be adequate physical and technical facilities for appropriate examination of survivors of sexual violation by a team of experienced psychiatrists, psychologists, gynaecologists and nurses, who are trained in the treatment of survivors of sexual torture. An additional purpose of the consultation after sexual assault is to offer support, advice and, if appropriate, reassurance. This should cover issues such as sexually transmitted diseases, HIV, pregnancy, if the victim is a woman, and permanent physical damage, because torturers often tell victims that they will never normally function sexually again, which can become a self-fulfilling prophecy.

(b) *Examination following a recent assault*

220. It is rare that a victim of rape during torture is released while it is still possible to identify acute signs of the assault. In these cases, there are many issues to be aware of that may impede the medical evaluation. Recently assaulted victims may be troubled and confused about seeking medical or legal help due to their fears, sociocultural concerns or the destructive nature of the abuse. In such cases, a doctor should explain to the victim all possible medical and judicial options and should act in accordance with the victim's wishes. The duties of the physician include obtention of voluntary informed consent for the examination, recording of all medical findings of abuse and obtention of samples for forensic examination. Whenever possible, the examination should be performed by an expert in documenting sexual assault. Otherwise, the examining physician should speak to an expert or consult a standard text on clinical forensic medicine.<sup>90</sup> When the physician is of a different gender from the victim, he or she should be offered the opportunity of having a chaperone of the same gender in the room. If an interpreter is used, then the interpreter may also fulfil the role of the chaperone. Given the sensitive nature of investigation into sexual assaults, a relative of the victim is not normally an ideal person to use in this role (see chapter IV, sect. I). The patient should be comfortable and relaxed before the examination. A thorough physical examination should be performed, including meticulous documentation of all physical findings, including size, location and colour, and, whenever possible, these findings should be photographed and evidence collected of specimens from the examination.

221. The physical examination should not initially be directed to the genital area. Any deformities should be noted. Particular attention must be given to ensure a thorough examination of the skin, looking for cutaneous lesions that could have resulted from an assault. These include bruises, lacerations, ecchymoses and petechiae from sucking or biting. This may help the patient to be more relaxed for a complete examination. When genital lesions are minimal, lesions located on other parts of the

body may be the most significant evidence of an assault. Even during examination of the female genitalia immediately after rape, there is identifiable damage in less than 50 per cent of the cases. Anal examination of men and women after anal rape shows lesions in less than 30 per cent of cases. Clearly, where relatively large objects have been used to penetrate the vagina or anus, the probability of identifiable damage is much greater.

222. Where a forensic laboratory is available, the facility should be contacted before the examination to discuss which types of specimen can be tested, and, therefore, which samples should be taken and how. Many laboratories provide kits to permit physicians to take all the necessary samples from individuals alleging sexual assault. If there is no laboratory available, it may still be worthwhile to obtain wet swabs and dry them later in the air. These samples can be used later for DNA testing. Sperm can be identified for up to five days from samples taken with a deep vaginal swab and after up to three days using a rectal sample. Strict precautions must be taken to prevent allegations of cross-contamination when samples have been taken from several different victims, particularly if they are taken from alleged perpetrators. There must be complete protection and documentation of the chain of custody for all forensic samples.

(c) *Examination after the immediate phase*

223. Where the alleged assault occurred more than a week earlier and there are no signs of bruises or lacerations, there is less immediacy in conducting a pelvic examination. Time can be taken to try to find the most qualified person to document findings and the best environment in which to interview the individual. However, it may still be beneficial to photograph residual lesions properly, if this is possible.

224. The background should be recorded as described above, then examination and documentation of the general physical findings. In women who have delivered babies before the rape, and particularly in those who have delivered them afterwards, pathognomonic findings are not likely, although an experienced female physician can tell a considerable amount from the demeanour of a woman when she is describing her history.<sup>91</sup> It may take some time before the individual is willing to discuss those aspects of the torture that he or she finds most embarrassing. Similarly, patients may wish to postpone the more intimate parts of the examination to a subsequent consultation, if time and circumstances permit.

(d) *Follow-up*

225. Many infectious diseases can be transmitted by sexual assault, including sexually transmitted diseases such as gonorrhoea, chlamydia, syphilis, HIV, hepatitis B and C, herpes simplex and *Condyloma acuminatum* (venereal warts), vulvovaginitis associated with sexual abuse, such as trichomoniasis, *Moniliasis vaginitis*, *Gardnerella vaginitis* and *Enterobius vermicularis* (pinworms), as well as urinary tract infections.

<sup>90</sup> See J. Howitt and D. Rogers, "Adult sexual offences and related matters", *Journal of Clinical Forensic Medicine*, W. D. S. McLay, ed. (London, Greenwich Medical Media, 1996), pp. 193-218.

<sup>91</sup> G. Hinshelwood, *Gender-based persecution* (Toronto, United Nations Expert Group Meeting on Gender-based Persecution, 1997).

226. Appropriate laboratory tests and treatment should be prescribed in all cases of sexual abuse. In the case of gonorrhoea and chlamydia, concomitant infection of the anus or oropharynx should be considered at least for examination purposes. Initial cultures and serologic tests should be obtained in cases of sexual assault, and appropriate therapy initiated. Sexual dysfunction is common among survivors of torture, particularly among victims who have suffered sexual torture or rape, but not exclusively. Symptoms may be physical or psychological in origin or a combination of both and include:

- (i) Aversion to members of the opposite sex or decreased interest in sexual activity;
- (ii) Fear of sexual activity because a sexual partner will know that the victim has been sexually abused or fear of having been damaged sexually. Torturers may have threatened this and instilled fear of homosexuality in men who have been anally abused. Some heterosexual men have had an erection and, on occasion, have ejaculated during non-consensual anal intercourse. They should be reassured that this is a physiological response;
- (iii) Inability to trust a sexual partner;
- (iv) Disturbance in sexual arousal and erectile dysfunction;
- (v) Dyspareunia (painful sexual intercourse in women) or infertility due to acquired sexually transmitted disease, direct trauma to reproductive organs or poorly performed abortions of pregnancies following rape.

(e) *Genital examination of women*

227. In many cultures, it is completely unacceptable to penetrate the vagina of a woman who is a virgin with anything, including a speculum, finger or swab. If the woman demonstrates clear evidence of rape on external inspection, it may be unnecessary to conduct an internal pelvic examination. Genital examination findings may include:

- (i) Small lacerations or tears of the vulva. These may be acute and are caused by excessive stretching. They normally heal completely, but, if repeatedly traumatized, there may be scarring;
- (ii) Abrasions of the female genitalia. Abrasions can be caused by contact with rough objects such as fingernails or rings;
- (iii) Vaginal lacerations. These are rare, but, if present, may be associated with atrophy of the tissues or previous surgery. They cannot be differentiated from incisions caused by inserted sharp objects.

228. It is rare to find any physical evidence when examining female genitalia more than one week after an assault. Later on, when the woman may have had subsequent sexual activity, whether consensual or not, or given birth, it may be almost impossible to attribute any findings to a specific incident of alleged abuse. Therefore, the most significant component of a medical evaluation may

be the examiner's assessment of background information (for example, correlation between allegations of abuse and acute injuries observed by the individual) and demeanour of the individual, bearing in mind the cultural context of the woman's experience.

(f) *Genital examination of men*

229. Men who have been subjected to torture of the genital region, including the crushing, wringing or pulling of the scrotum or direct trauma to that region, usually complain of pain and sensitivity in the acute period. Hyperaemia, marked swelling and ecchymosis can be observed. The urine may contain a large number of erythrocytes and leucocytes. If a mass is detected, it should be determined whether it is a hydrocele, haematocele or inguinal hernia. In the case of an inguinal hernia, the examiner cannot palpate the spermatic cord above the mass. With a hydrocele or a haematocele, normal spermatic cord structures are usually palpable above the mass. A hydrocele results from excessive accumulation of fluid within the tunica vaginalis due to inflammation of the testis and its appendages or to diminished drainage secondary to lymphatic or venous obstruction in the cord or retroperitoneal space. A haematocele is an accumulation of blood within the tunica vaginalis, secondary to trauma. Unlike the hydrocele, it does not transilluminate.

230. Testicular torsion may also result from trauma to the scrotum. With this injury, the testis becomes twisted at its base, obstructing blood flow to the testis. This causes severe pain and swelling and constitutes a surgical emergency. Failure to reduce the torsion immediately will lead to infarction of the testis. Under conditions of detention, where medical care may be denied, late sequelae of this lesion may be observed.

231. Individuals who were subject to scrotal torture may suffer from chronic urinary tract infection, erectile dysfunction or atrophy of the testes. Symptoms of PTSD are not uncommon. In the chronic phase, it may be impossible to distinguish between scrotal pathology caused by torture and that caused by other disease processes. Failure to discover any physical abnormalities on full urological examination suggests that urinary symptoms, impotence or other sexual problems may be explained on psychological grounds. Scars on the skin of the scrotum and penis may be very difficult to visualize. For this reason, the absence of scarring at these specific locations does not demonstrate the absence of torture. On the other hand, the presence of scarring usually indicates that substantial trauma was sustained.

(g) *Examination of the anal region*

232. After anal rape or insertion of objects into the anus of either gender, pain and bleeding can occur for days or weeks. This often leads to constipation, which can be exacerbated by the poor diet in many places of detention. Gastrointestinal and urinary symptoms may also occur. In the acute phase, any examination beyond visual inspection may require local or general anaesthesia and should be performed by a specialist. In the chronic phase, several symptoms may persist, and they should be investigated. There may be anal scars of unusual size or position, and these should be documented. Anal fissures may persist for many years, but it is normally impossible to

differentiate between those caused by torture and those caused by other mechanisms. On examination of the anus, the following findings should be looked for and documented:

- (i) Fissures tend to be non-specific findings as they can occur in a number of "normal" situations (constipation, poor hygiene). However, when seen in an acute situation (i.e. within 72 hours) fissures are a more specific finding and can be considered evidence of penetration;
- (ii) Rectal tears with or without bleeding may be noted;
- (iii) Disruption of the rugal pattern may manifest as smooth fan-shaped scarring. When these scars are seen out of midline (i.e. not at 12 or 6 o'clock), they can be an indication of penetrating trauma;
- (iv) Skin tags, which can be the result of healing trauma;
- (iv) Purulent discharge from the anus. Cultures should be taken for gonorrhoea and chlamydia in all cases of alleged rectal penetration, regardless of whether a discharge is noted.

## **E. Specialized diagnostic tests**

233. Diagnostic tests are not an essential part of the clinical assessment of a person alleging having been tortured. In many cases, a medical history and physical examination are sufficient. However, there are circumstances in which such tests are valuable supporting evidence. For example, where there is a legal case against members of the authorities or a claim for compensation. In these cases, a positive test might make the difference between a case succeeding or failing. Additionally, if diagnostic tests are performed for therapeutic reasons, the results should be added to the clinical report. It must be recognized that the absence of a positive diagnostic test result, as with physical findings, must not be used to suggest that torture has not occurred. There are many situations in which diagnostic tests are not available for technical reasons, but their absence should never invalidate an otherwise properly written report. It is inappropriate to use limited diagnostic facilities to document injuries for legal reasons alone, when there are greater clinical needs for those facilities (for further details, see annex II).

## CHAPTER VI

## PSYCHOLOGICAL EVIDENCE OF TORTURE

## A. General considerations

1. *The central role of the psychological evaluation*

234. It is a widely held view that torture is an extraordinary life experience capable of causing a wide range of physical and psychological suffering. Most clinicians and researchers agree that the extreme nature of the torture event is powerful enough on its own to produce mental and emotional consequences, regardless of the individual's pre-torture psychological status. The psychological consequences of torture, however, occur in the context of personal attribution of meaning, personality development and social, political and cultural factors. For this reason, it cannot be assumed that all forms of torture have the same outcome. For example, the psychological consequences of a mock execution are not the same as those due to a sexual assault, and solitary confinement and isolation are not likely to produce the same effects as physical acts of torture. Likewise, one cannot assume that the effects of detention and torture on an adult will be the same as those on a child. Nevertheless, there are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity.

235. Perpetrators often attempt to justify their acts of torture and ill-treatment by the need to gather information. Such conceptualizations obscure the purpose of torture and its intended consequences. One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioural functions.<sup>92</sup> Thus, torture is a means of attacking an individual's fundamental modes of psychological and social functioning. Under such circumstances, the torturer strives not only to incapacitate a victim physically but also to disintegrate the individual's personality. The torturer attempts to destroy a victim's sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future. By dehumanizing and breaking the will of their victims, torturers set horrific examples for those who later come in contact with the victim. In this way, torture can break or damage the will and coherence of entire communities. In addition, torture can profoundly damage intimate relationships between spouses, parents, children, other family members and relationships between the victims and their communities.

<sup>92</sup> G. Fischer and N. F. Gurrus, "Grenzverletzungen: Folter und sexuelle Traumatisierung", *Praxis der Psychotherapie—Ein integratives Lehrbuch für Psychoanalyse und Verhaltenstherapie*, W. Senf and M. Broda, eds. (Stuttgart, Thieme, 1996).

236. It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness. However, many victims experience profound emotional reactions and psychological symptoms. The main psychiatric disorders associated with torture are PTSD and major depression. While these disorders are present in the general population, their prevalence is much higher among traumatized populations. The unique cultural, social and political implications that torture has for each individual influence his or her ability to describe and speak about it. These are important factors that contribute to the impact that torture inflicts psychologically and socially and that must be considered when performing an evaluation of an individual from another culture. Cross-cultural research reveals that phenomenological or descriptive methods are the most rational approaches to use when attempting to evaluate psychological or psychiatric disorders. What is considered disordered behaviour or a disease in one culture may not be viewed as pathological in another.<sup>93, 94, 95</sup> Since the Second World War, progress has been made towards understanding the psychological consequences of violence. Certain psychological symptoms and clusters of symptoms have been observed and documented among survivors of torture and other types of violence.

237. In recent years, the diagnosis of PTSD has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violence. However, the utility of this diagnosis in non-Western cultures has not been established. Nevertheless, evidence suggests that there are high rates of PTSD and depression symptoms among traumatized refugee populations from many different ethnic and cultural backgrounds.<sup>96, 97, 98</sup> The World Health Organization's cross-

<sup>93</sup> A. Kleinman, "Anthropology and psychiatry: the role of culture in cross-cultural research on illness and care", paper delivered at the World Psychiatric Association regional symposium on psychiatry and its related disciplines, 1986.

<sup>94</sup> H. T. Engelhardt, "The concepts of health and disease", *Evaluation and Explanation in the Biomedical Sciences*, H. T. Engelhardt and S. F. Spicker, eds. (Dordrecht, D. Reidel Publishing Co., 1975), pp. 125-141.

<sup>95</sup> J. Westermeyer, "Psychiatric diagnosis across cultural boundaries", *American Journal of Psychiatry*, vol. 142 (7) (1985), pp. 798-805.

<sup>96</sup> R. F. Mollica and others, "The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps", *Journal of the American Medical Association (JAMA)*, vol. 270 (1993), pp. 581-586.

<sup>97</sup> J. D. Kinzie and others, "The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees", *American Journal of Psychiatry*, vol. 147 (7) (1990), pp. 913-917.

<sup>98</sup> K. Alden and others, "Burmese political dissidents in Thailand: trauma and survival among young adults in exile", *American Journal of Public Health*, vol. 86 (1996), pp. 1561-1569.

cultural study of depression provides helpful information.<sup>99</sup> While some symptoms may be present across different cultures, they may not be the symptoms that concern the individual the most.

## 2. *The context of the psychological evaluation*

238. Evaluations take place in a variety of political contexts. This results in important differences in the manner in which an evaluation should be conducted. The physician or psychologist must adapt the following guidelines to the particular situation and purpose of the evaluation (see chapter III, sect. C.2).

239. Whether or not certain questions can be asked safely will vary considerably and depends on the degree to which confidentiality and security can be ensured. For example, an examination in a prison by a visiting physician, that is limited to 15 minutes, cannot follow the same course as a forensic examination in a private office that may last for several hours. Additional problems arise when trying to assess whether psychological symptoms or behaviours are pathological or adaptive. When a person is examined while in detention or living under considerable threat or oppression, some symptoms may be adaptive. For example, diminished interest in activities and feelings of detachment or estrangement would be understandable in a person in solitary confinement. Likewise, hypervigilance and avoidance behaviours may be necessary for persons living in repressive societies.<sup>100</sup> The limitations of certain conditions for interviews, however, do not preclude aspiring to application of the guidelines set forth in this manual. It is especially important in difficult circumstances that governments and authorities involved be held to these standards as much as possible.

## B. Psychological consequences of torture

### 1. *Cautionary remarks*

240. Before entering into a technical description of symptoms and psychiatric classifications, it should be noted that psychiatric classifications are generally considered to be Western medical concepts and that their application to non-Western populations presents, either implicitly or explicitly, certain difficulties. It can be argued that Western cultures suffer from an undue medicalization of psychological processes. The idea that mental suffering represents a disorder that resides in an individual and features a set of typical symptoms may be unacceptable to many members of non-Western societies. Nonetheless, there is considerable evidence of biological changes that occur in PTSD and, from that perspective,

PTSD is a diagnosable syndrome amenable to treatment biologically and psychologically.<sup>101</sup> As much as possible, the evaluating physician or psychologist should attempt to relate to mental suffering in the context of the individual's beliefs and cultural norms. This includes respect for the political context as well as cultural and religious beliefs. Given the severity of torture and its consequences, when performing a psychological evaluation, an attitude of informed learning should be adopted rather than one of rushing to diagnose and classify. Ideally, this attitude will communicate to the victim that his or her complaints and suffering are being recognized as real and expectable under the circumstances. In this sense, a sensitive empathic attitude may offer the victim some relief from the experience of alienation.

## 2. *Common psychological responses*

### (a) *Re-experiencing the trauma*

241. A victim may have flashbacks or intrusive memories, in which the traumatic event is happening all over again, even while the person is awake and conscious, or recurrent nightmares, which include elements of the traumatic event in their original or symbolic form. Distress at exposure to cues that symbolize or resemble the trauma is frequently manifested by a lack of trust and fear of persons in authority, including physicians and psychologists. In countries or situations where authorities participate in human rights violations, lack of trust and fear of authority figures should not be assumed to be pathological.

### (b) *Avoidance and emotional numbing*

- (i) Avoidance of any thought, conversation, activity, place or person that arouses a recollection of the trauma;
- (ii) Profound emotional constriction;
- (iii) Profound personal detachment and social withdrawal;
- (iv) Inability to recall an important aspect of the trauma.

### (c) *Hyperarousal*

- (i) Difficulty either falling or staying asleep;
- (ii) Irritability or outbursts of anger;
- (iii) Difficulty concentrating;
- (iv) Hypervigilance, exaggerated startled response;
- (v) Generalized anxiety;
- (vi) Shortness of breath, sweating, dry mouth or dizziness and gastrointestinal distress.

<sup>99</sup> N. Sartorius, "Cross-cultural research on depression", *Psychopathology*, vol. 19 (2) (1987), pp. 6-11.

<sup>100</sup> M. A. Simpson, "What went wrong?: diagnostic and ethical problems in dealing with the effects of torture and repression in South Africa", *Beyond Trauma: Cultural and Societal Dynamics*, R. J. Kleber, C. R. Figley, B. P. R. Gersons, eds. (New York, Plenum Press, 1995), pp.188-210.

<sup>101</sup> M. Friedman and J. Jaranson, "The applicability of the post-traumatic stress disorder concept to refugees", *Amidst Peril and Pain: The Mental Health and Well-being of the World's Refugees*, A. Marsella and others, eds. (Washington, D. C., American Psychological Association, 1994), pp. 207-227.

(d) *Symptoms of depression*

242. The following symptoms of depression may be present: depressed mood, anhedonia (markedly diminished interest or pleasure in activities), appetite disturbance or weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue and loss of energy, feelings of worthlessness and excessive guilt, difficulty paying attention, concentrating or recalling from memory, thoughts of death and dying, suicidal ideation or attempted suicide.

(e) *Damaged self-concept and foreshortened future*

243. The victim has a subjective feeling of having been irreparably damaged and having undergone an irreversible personality change.<sup>102</sup> He or she has a sense of foreshortened future without expectation of a career, marriage, children or normal lifespan.

(f) *Dissociation, depersonalization and atypical behaviour*

244. Dissociation is a disruption in the integration of consciousness, self-perception, memory and actions. A person may be cut off or unaware of certain actions or may feel split in two as if observing him or herself from a distance. Depersonalization is feeling detached from oneself or one's body. Impulse control problems result in behaviours that the survivor considers highly atypical with respect to his or her pre-trauma personality. A previously cautious individual may engage in high-risk behaviour.

(g) *Somatic complaints*

245. Somatic symptoms such as pain, headache or other physical complaints, with or without objective findings, are common problems among torture victims. Pain may be the only manifest complaint and may shift in location and vary in intensity. Somatic symptoms can be directly due to physical consequences of torture or psychological in origin. For example, pain of all kinds may be a direct physical consequence of torture or of psychological origin. Typical somatic complaints include back pain, musculoskeletal pain and headaches, often from head injuries. Headaches are very common among torture survivors and often lead to chronic post-traumatic headaches. They may also be caused or exacerbated by tension and stress.

(h) *Sexual dysfunction*

246. Sexual dysfunction is common among survivors of torture, particularly among those who have suffered sexual torture or rape, but not exclusively (see chapter V, sect. D.8).

(i) *Psychosis*

247. Cultural and linguistic differences may be confused with psychotic symptoms. Before labelling some-

one as psychotic, the symptoms must be evaluated within the individual's unique cultural context. Psychotic reactions may be brief or prolonged, and the symptoms may occur while the person is detained and tortured or afterwards. The following findings are possible:

- (i) Delusions;
- (ii) Auditory, visual, tactile and olfactory hallucinations;
- (iii) Bizarre ideation and behaviour;
- (iv) Illusions or perceptual distortions that may take the form of pseudo-hallucinations and border on true psychotic states. False perceptions and hallucinations that occur on falling asleep or on waking are common among the general population and do not denote psychosis. It is not uncommon for torture victims to report occasionally hearing screams, their name being called or seeing shadows, but not to have florid signs or symptoms of psychosis;
- (v) Paranoia and delusions of persecution;
- (vi) Recurrence of psychotic disorders or mood disorders with psychotic features may develop among those who have a past history of mental illness. Individuals with a past history of bipolar disorder, recurrent major depression with psychotic features, schizophrenia and schizoaffective disorder may experience an episode of that disorder.

(j) *Substance abuse*

248. Alcohol and drug abuse often develop secondarily in torture survivors as a way of obliterating traumatic memories, regulating affects and managing anxiety.

(k) *Neuropsychological impairment*

249. Torture can cause physical trauma that leads to various levels of brain impairment. Blows to the head, suffocation and prolonged malnutrition may have long-term neurological and neuropsychological consequences that may not be readily assessed during the course of a medical examination. As in all cases of brain impairment that cannot be documented through head imaging or other medical procedures, neuropsychological assessment and testing may be the only reliable way of documenting the effects. Frequently, the target symptoms for such assessments have significant overlap with the symptomatology arising from PTSD and major depressive disorder. Fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning may result from functional disturbances as well as have organic causes. Therefore, specialized skill in neuropsychological assessment and awareness of problems in cross-cultural validation of neuropsychological instruments are necessary when such distinctions are to be made (see section C.4 below).

### 3. *Diagnostic classifications*

250. While the chief complaints and most prominent findings among torture survivors are widely diverse and relate to the individual's unique life experiences and his or

<sup>102</sup> N. R. Holtan, "How medical assessment of victims of torture relates to psychiatric care", *Caring for Victims of Torture*, J. M. Jaranson and M. K. Popkin, eds. (Washington, D. C., American Psychiatric Press, 1998), pp. 107-113.

her cultural, social and political context, it is wise for evaluators to become familiar with the most commonly diagnosed disorders among trauma and torture survivors. Also, it is not uncommon for more than one mental disorder to be present, as there is considerable co-morbidity among trauma-related mental disorders. Various manifestations of anxiety and depression are the most common symptoms resulting from torture. Not infrequently, the symptomatology described above will be classified within the categories of anxiety and mood disorders. The two prominent classification systems are the International Classification of Disease (ICD-10)<sup>103</sup> classification of mental and behavioural disorders and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).<sup>104</sup> For complete descriptions of diagnostic categories, the reader should refer to ICD-10 and DSM-IV. This review will focus on the most common trauma-related diagnoses: PTSD, major depression and enduring personality changes.

(a) *Depressive disorders*

251. Depressive states are almost ubiquitous among survivors of torture. In the context of evaluating the consequences of torture, it is problematic to assume that PTSD and major depressive disorder are two separate disease entities with clearly distinguishable aetiologies. Depressive disorders include major depressive disorder, single episode or major depressive disorder and recurrent (more than one episode). Depressive disorders can be present with or without psychotic, catatonic, melancholic or atypical features. According to DSM-IV, in order to make a diagnosis of major depressive episode, five or more of the following symptoms must be present during the same two-week period and represent a change from previous functioning (at least one of the symptoms must be depressed mood or loss of interest or pleasure): (1) depressed mood; (2) markedly diminished interest or pleasure in all or almost all activities; (3) weight loss or change of appetite; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness or excessive or inappropriate guilt; (8) diminished ability to think or concentrate; and (9) recurrent thoughts of death or suicide. To make this diagnosis the symptoms must cause significant distress or impaired social or occupational functioning, not be due to a physiological disorder and unaccounted for by another DSM-IV diagnosis.

(b) *Post-traumatic stress disorder*

252. The diagnosis most commonly associated with the psychological consequences of torture is PTSD. The association between torture and this diagnosis has become very strong in the minds of health providers, immigration courts and the informed lay public. This has created the mistaken and simplistic impression that PTSD is the main psychological consequence of torture.

253. The DSM-IV definition of PTSD relies heavily on the presence of memory disturbances in relation to the trauma, such as intrusive memories, nightmares and the inability to recall important aspects of the trauma. The individual may be unable to recall with precision specific details of the torture events but will be able to recall the major themes of the torture experiences. For example, the victim may be able to recall being raped on several occasions but not be able to give the exact dates, locations and details of the setting or the perpetrators. Under such circumstances, the inability to recall precise details supports, rather than discounts, the credibility of a survivor's story. Major themes in the story will be consistent upon re-interviewing. The ICD-10 diagnosis of PTSD is very similar to that of DSM-IV. According to DSM-IV, PTSD can be acute, chronic or delayed. The symptoms must be present for more than one month and the disturbance must cause significant distress or impairment in functioning. In order to diagnose PTSD, the individual must have been exposed to a traumatic event that involved life-threatening experiences for the victim or others and produced intense fear, helplessness or horror. The event must be re-experienced persistently in one or more of the following ways: intrusive distressing recollections of the event, recurrent distressing dreams of the event, acting or feeling as if the event were happening again including hallucinations, flashbacks and illusions, intense psychological distress at exposure to reminders of the event and physiological reactivity when exposed to cues that resemble or symbolize aspects of the event.

254. The individual must persistently demonstrate avoidance of stimuli associated with the traumatic event or show general numbing of responsiveness as indicated by at least three of the following: (1) efforts to avoid thoughts, feelings or conversations associated with the trauma; (2) efforts to avoid activities, places or people that remind the victim of the trauma; (3) inability to recall an important aspect of the event; (4) diminished interest in significant activities; (5) detachment or estrangement from others; (6) restricted affect; and (7) foreshortened sense of future. Another reason to make a DSM-IV diagnosis of PTSD is the persistence of symptoms of increased arousal that were not present before the trauma, as indicated by at least two of the following: difficulty falling or staying asleep, irritability or angry outbursts, difficulty concentrating, hypervigilance and exaggerated startle response.

255. Symptoms of PTSD can be chronic or fluctuate over extended periods of time. During some intervals, symptoms of hyperarousal and irritability dominate the clinical picture. At these times, the survivor will usually also report increased intrusive memories, nightmares and flashbacks. At other times, the survivor may appear relatively asymptomatic or emotionally constricted and withdrawn. It must be kept in mind that not meeting diagnostic criteria of PTSD does not mean that torture was not inflicted. According to ICD-10, in a certain proportion of cases PTSD may follow a chronic course over many years with eventual transition to an enduring personality change.

<sup>103</sup> World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders* (Geneva, 1994).

<sup>104</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*, 4th ed. (Washington, D.C., 1994).

(c) *Enduring personality change*

256. After catastrophic or prolonged extreme stress, disorders of adult personality may develop in persons with no previous personality disorder. The types of extreme stress that can change the personality include concentration camp experiences, disasters, prolonged captivity with an imminent possibility of being killed, exposure to life-threatening situations, such as being a victim of terrorism, and torture. According to ICD-10, the diagnosis of an enduring change in personality should be made only when there is evidence of a definite, significant and persistent change in the individual's pattern of perceiving, relating or thinking about the environment and him or herself, associated with inflexible and maladaptive behaviours not present before the traumatic experience. The diagnosis excludes changes that are a manifestation of another mental disorder or a residual symptom of any antecedent mental disorder, as well as personality and behavioural changes due to brain disease, dysfunction or damage.

257. To make the ICD-10 diagnosis of enduring personality change after catastrophic experience, the changes in personality must be present for at least two years following exposure to catastrophic stress. ICD-10 specifies that the stress must be so extreme that "it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality". This personality change is characterized by a hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge", as if constantly threatened, and estrangement.

(d) *Substance abuse*

258. Clinicians have observed that alcohol and drug abuse often develop secondarily in torture survivors as a way of suppressing traumatic memories, regulating unpleasant affects and managing anxiety. Although comorbidity of PTSD with other disorders is common, systematic research has seldom studied the abuse of substances by torture survivors. The literature on populations that suffer from PTSD may include torture survivors, such as refugees, prisoners of war and veterans of armed conflicts, and may provide some insight. Studies of these groups reveal that prevalence of substance abuse varies by ethnic or cultural group. Former prisoners of war with PTSD were at increased risk of substance abuse, and combat veterans have high rates of co-morbidity of PTSD and substance abuse.<sup>105, 106, 107, 108, 109, 110, 111, 112</sup> In sum-

mary, there is considerable evidence from other populations at risk of PTSD that substance abuse is a potential co-morbid diagnosis for torture survivors.

(e) *Other diagnoses*

259. As is evident from the catalogue of symptoms described in this section, there are other diagnoses to be considered in addition to PTSD, such as major depressive disorder and enduring personality change. The other possible diagnoses include but are not limited to:

- (i) Generalized anxiety disorder features excessive anxiety and worry about a variety of different events or activities, motor tension and increased autonomic activity;
- (ii) Panic disorder is manifested by recurrent and unexpected attacks of intense fear or discomfort, including symptoms such as sweating, choking, trembling, rapid heart rate, dizziness, nausea, chills or hot flushes;
- (iii) Acute stress disorder has essentially the same symptoms as PTSD but is diagnosed within one month of exposure to the traumatic event;
- (iv) Somatoform disorders featuring physical symptoms that cannot be accounted for by a medical condition;
- (v) Bipolar disorder featuring manic or hypomanic episodes with elevated, expansive or irritable mood, grandiosity, decreased need for sleep, flight of ideas, psychomotor agitation and associated psychotic phenomena;
- (vi) Disorders due to a general medical condition often in the form of brain impairment with resultant fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning;
- (vii) Phobias such as social phobia and agoraphobia.

C. *The psychological/psychiatric evaluation*1. *Ethical and clinical considerations*

260. Psychological evaluations can provide critical evidence of abuse among torture victims for several reasons: torture often causes devastating psychological symptoms, torture methods are often designed to leave no physical lesions and physical methods of torture may result in physical findings that either resolve or lack specificity.

<sup>110</sup> R. A. Kulka and others, *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study* (New York, Brunner/Mazel, 1990).

<sup>111</sup> B. K. Jordan and others, "Lifetime and current prevalence of specific psychiatric disorders among Vietnam veterans and controls", *Archives of General Psychiatry*, vol. 48, No. 3 (1991), pp. 207-215.

<sup>112</sup> A. Y. Shalev, A. Bleich and R. J. Ursano, "Posttraumatic stress disorder: somatic comorbidity and effort tolerance", *Psychosomatics*, vol. 31 (1990), pp.197-203.

<sup>105</sup> P. J. Farias, "Emotional distress and its socio-political correlates in Salvadoran refugees: analysis of a clinical sample", *Culture, Medicine and Psychiatry*, vol. 15 (1991), pp. 167-192.

<sup>106</sup> A. Dadfar, "The Afghans: bearing the scars of a forgotten war", *Amidst Peril and Pain: The Mental Health and Well-being of the World's Refugees*, A. Marsella and others (Washington, D. C., American Psychological Association, 1994).

<sup>107</sup> G. W. Beebe, "Follow-up studies of World War II and Korean war prisoners: II. Morbidity, disability, and maladjustments", *American Journal of Epidemiology*, vol. 101 (1975), pp. 400-422.

<sup>108</sup> B. E. Engdahl and others, "Comorbidity and course of psychiatric disorders in a community sample of former prisoners of war", *American Journal of Psychiatry*, vol. 155 (1998), pp. 1740-1745.

<sup>109</sup> T. M. Keane and J. Wolfe, "Comorbidity in post-traumatic stress disorder: an analysis of community and clinical studies", *Journal of Applied Social Psychology*, vol. 20 (21) (1990), pp. 1776-1788.



261. Psychological evaluations provide useful evidence for medico-legal examinations, political asylum applications, establishing conditions under which false confessions may have been obtained, understanding regional practices of torture, identifying the therapeutic needs of victims and as testimony in human rights investigations. The overall goal of a psychological evaluation is to assess the degree of consistency between an individual's account of torture and the psychological findings observed during the course of the evaluation. To this end, the evaluation should provide a detailed description of the individual's history, a mental status examination, an assessment of social functioning and the formulation of clinical impressions (see chapters III, sect. C, and IV, sect. E). A psychiatric diagnosis should be made, if appropriate. Because psychological symptoms are so prevalent among survivors of torture, it is highly advisable for any evaluation of torture to include a psychological assessment.

262. The assessment of psychological status and the formulation of a clinical diagnosis should always be made with an awareness of the cultural context. Awareness of culture-specific syndromes and native language-bound idioms of distress through which symptoms are communicated is of paramount importance for conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge of the victim's culture, the assistance of an interpreter is essential. Ideally, an interpreter from the victim's country knows the language, customs, religious traditions and other beliefs that must be taken into account during the investigation. The interview may induce fear and mistrust on the part of the victim and possibly remind him or her of previous interrogations. To reduce the effects of re-traumatization, the clinician should communicate a sense of understanding of the individual's experiences and cultural background. It is inappropriate to observe the strict "clinical neutrality" that is used in some forms of psychotherapy, during which the clinician is inactive and says little. The clinician should communicate that he or she is an ally of the individual and adopt a supportive, non-judgmental approach.

## 2. *The interview process*

263. The clinician should introduce the interview process in a manner that explains in detail the procedures to be followed (questions asked about psychosocial history, including history of torture and current psychological functioning) and that prepares the individual for the difficult emotional reactions that the questions may provoke. The individual needs to be given an opportunity to request breaks, interrupt the interview at any time and be able to leave if the stress becomes intolerable, with the option of a later appointment. Clinicians need to be sensitive and empathic in their questioning, while remaining objective in their clinical assessment. At the same time, the interviewer should be aware of potential personal reactions to the survivor and the descriptions of torture that might influence the interviewer's perceptions and judgements.

264. The interview process may remind the survivor of interrogation during torture. Therefore, strong negative

feelings towards the clinician may develop, such as fear, rage, revulsion, helplessness, confusion, panic or hatred. The clinician should allow for the expression and explanation of such feelings and express understanding for the individual's difficult predicament. In addition, the possibility that the person may still be persecuted or oppressed has to be kept in mind. When necessary, questions about forbidden activities should be avoided. It is important to consider the reasons for the psychological evaluation, as they will determine the level of confidentiality to which the expert is bound. If an evaluation of the credibility of an individual's report of torture is requested within the framework of a judicial procedure by a State authority, the person to be evaluated must be told that this implies lifting medical confidentiality for all the information presented in the report. However, if the request for the psychological evaluation comes from the tortured person, the expert must respect medical confidentiality.

265. Clinicians who conduct physical or psychological evaluations should be aware of the potential emotional reactions that evaluations of severe trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and countertransference. Mistrust, fear, shame, rage and guilt are among the typical reactions that torture survivors experience, particularly when being asked to recount or remember details of their trauma. Transference refers to the feelings a survivor has towards the clinician that relate to past experiences but which are misunderstood as directed towards the clinician personally. In addition, the clinician's emotional response to the torture survivor, known as countertransference, may affect the psychological evaluation. Transference and countertransference are mutually interdependent and interactive.

266. The potential impact of transference reactions on the evaluation process becomes evident when it is considered that an interview or examination that involves recounting and remembering the details of a traumatic history will result in exposure to distressing and unwanted memories, thoughts and feelings. Thus, even though a torture victim may consent to an evaluation with the hope of benefiting from it, the resulting exposure may renew the trauma experience itself. This may include the following phenomena.

267. The evaluator's questions may be experienced as forced exposure akin to an interrogation. The evaluator may be suspected of having voyeuristic or sadistic motivations, and the interviewee may ask him or herself questions such as: "Why does he or she make me reveal every last terrible detail of what happened to me? Why would a normal person choose to listen to stories like mine in order to make a living? The evaluator must have some strange kind of motivation." There may be prejudices towards the evaluator because he or she has not been arrested and tortured. This may lead the subject to perceive the evaluator as being on the side of the enemy.

268. The evaluator is perceived as a person in a position of authority, which is often the case, and for that reason may not be trusted with certain aspects of the trauma history. Alternatively, as is often the case with subjects still in custody, the subject may be too trusting in situations where the interviewer cannot guarantee that there

will be no reprisals. Every precaution should be taken to ensure that prisoners do not put themselves at risk unnecessarily, naively trusting the outsider to protect them. Torture victims may fear that information that is revealed in the context of an evaluation cannot be safely kept from persecuting governments. Fear and mistrust may be particularly strong in cases where physicians or other health workers have been participants in the torture.

269. In many circumstances, the evaluator will be a member of the majority culture and ethnicity, whereas the subject, in the situation of the interview, will belong to a minority group or culture. This dynamic of inequality may reinforce the perceived and real imbalance of power and may increase the potential sense of fear, mistrust and forced submission in the subject. In some cases, particularly with subjects still in custody, this dynamic may relate more to the interpreter than to the evaluator. Ideally, therefore, the interpreter should also be an outsider and not be recruited locally, so that he or she can be seen by all to be as independent as the investigator. Of course, a family member on whom the authorities can later apply pressure to find out what was discussed in the evaluation should not be used as an interpreter.

270. If the evaluator and the victim are of the same gender, the interview may be more readily perceived as directly resembling the torture situation than if the genders were different. For example, a woman who was raped or tortured in prison by a male guard is likely to experience more distress, mistrust and fear when facing a male evaluator than she might with a female interviewer. The opposite is true for men who have been assaulted sexually. They may be ashamed to tell the details of their torture to a female evaluator. Experience has shown, particularly in cases of victims still in custody, that in all but the most traditionally fundamentalist societies (where it is out of the question for a male to even interview, let alone examine, a woman), it may be much more important that the interviewer be a physician to whom the victim can ask precise questions, rather than not being a male as in a case of rape. Victims of rape have been known to say nothing to non-medical female investigators, but to request to talk to a physician, even if male, so as to be able to ask specific medical questions. Typical questions are about possible sequelae, such as being pregnant, being able to conceive later on or about the future of sexual relations between spouses. In the context of evaluations conducted for legal purposes, the necessary attention to detail and precise questioning about history are easily perceived as a sign of mistrust or doubt on the part of the examiner.

271. Because of the psychological pressures mentioned earlier, survivors may be re-traumatized and overwhelmed by memories and, as a result, affect or mobilize strong defences that result in profound withdrawal and affective flattening during examination or interview. For the purposes of documentation, the withdrawal and flattening present special difficulties because torture victims may be unable to communicate their history and current suffering effectively, although it would be most beneficial for them to do so.

272. Countertransference reactions are often unconscious, and when a person is unaware of countertransfer-

ence, it becomes a problem. Having feelings when listening to individuals speak of their torture is to be expected, although these feelings can interfere with the clinician's effectiveness, but when understood they can guide the clinician. Physicians and psychologists involved in the evaluation and treatment of torture victims agree that awareness and understanding of typical countertransference reactions are crucial because countertransference can have significantly limiting effects on the ability to evaluate and document the physical and psychological consequences of torture. Effective documentation of torture and other forms of ill-treatment requires an understanding of personal motivations for working in this area. There is a consensus that professionals who continuously conduct this kind of examination should obtain supervision and professional support from peers who are experienced in this field. Common countertransference reactions include:

(a) Avoidance, withdrawal and defensive indifference in reaction to being exposed to disturbing material. This may lead to forgetting some details and underestimating the severity of physical or psychological consequences;

(b) Disillusionment, helplessness, hopelessness and overidentification that may lead to symptoms of depression or vicarious traumatization, such as nightmares, anxiety and fear;

(c) Omnipotence and grandiosity in the form of feeling like a saviour, the great expert on trauma or the last hope for the survivor's recovery and well-being;

(d) Feelings of insecurity about professional skills when faced with the gravity of the reported history or suffering. This may manifest as lack of confidence in the ability to do justice to the survivor and unrealistic preoccupation with idealized medical norms;

(e) Feelings of guilt over not sharing the torture survivor's experience and pain or over the awareness of what has not been done on a political level may result in overly sentimental or idealized approaches to the survivor;

(f) Anger and rage towards torturers and persecutors are expectable, but may undermine the ability to maintain objectivity when they are driven by unrecognized personal experiences and thus become chronic or excessive;

(g) Anger or repugnance against the victim may arise as a result of feeling exposed to unaccustomed levels of anxiety. This may also arise as a result of feeling used by the victim when the clinician experiences doubt about the truth of the alleged torture history and the victim stands to benefit from an evaluation that documents the consequences of the alleged incident;

(h) Significant differences between the cultural value systems of the clinician and the individual alleging torture may include belief in myths about ethnic groups, condescending attitudes and underestimation of the individual's sophistication or capacity for insight. Conversely, clinicians who are members of the same ethnic group as a victim might form a non-verbalized alliance that can also affect the objectivity of the evaluation.

273. Most clinicians agree that many countertransference reactions are not merely examples of distortion but are important sources of information about the psychological state of the torture victim. The clinician's effectiveness can be compromised when countertransference is acted upon rather than reflected upon. Clinicians engaged in the evaluation and treatment of torture victims are advised to examine countertransference and obtain supervision and consultation from a colleague, if possible.

274. Circumstances may require that interviews be conducted by a clinician from a cultural or linguistic group different from that of the survivor. In such cases, there are two possible approaches; each with advantages and disadvantages. The interviewer can use literal, word-for-word translations provided by an interpreter (see chapter IV, sect. I). Alternatively, the interviewer can use a bicultural approach to interviewing. This approach consists of using an interviewing team composed of the investigating clinician and an interpreter, who provides linguistic interpretation and facilitates an understanding of cultural meanings attached to events, experiences, symptoms and idioms. Because the clinician often does not recognize relevant cultural, religious and social factors, a skilled interpreter will be able to point out and explain these issues to the clinician. If the interviewer is relying strictly on literal, word-for-word interpretation, this type of in-depth interpretation of information will not be available. On the other hand, if interpreters are expected to point out relevant cultural, religious and social factors to the clinician, it is crucial that they do not attempt to influence in any way the tortured person's responses to the clinician's questions. When literal translation is not used, the clinician needs to be sure that the interviewee's responses, as communicated by the interpreter, represent exclusively what the person said without additions or deletions by the interpreter. Regardless of the approach, the interpreter's identity and ethnic, cultural and political affiliation are important considerations in the choice of an interpreter. The torture victim will have to trust the interpreter to understand what he or she is saying and to communicate it accurately to the investigating clinician. Under no circumstances should the interpreter be a law enforcement official or government employee. A family member should never be used as an interpreter, in order to respect privacy. The investigating team must choose an independent interpreter.

### 3. *Components of the psychological/psychiatric evaluation*

275. The introduction should contain mention of the referral source, a summary of collateral sources (such as medical, legal and psychiatric records) and a description of the methods of assessment used (interviews, symptom inventories, checklists and neuropsychological testing).

#### (a) *History of torture and ill-treatment*

276. Every effort should be made to document the full history of torture, persecution and other relevant traumatic experiences (see chapter IV, sect. E). This part of the evaluation is often exhausting for the person being evaluated. Therefore, it may be necessary to proceed in

several sessions. The interview should start with a general summary of events before eliciting the details of the torture experiences. The interviewer needs to know the legal issues at hand because that will determine the nature and amount of information necessary to achieve documentation of the facts.

#### (b) *Current psychological complaints*

277. An assessment of current psychological functioning constitutes the core of the evaluation. As severely brutalized prisoners of war and rape victims show a lifetime prevalence of PTSD of between 80 and 90 per cent, specific questions about the three DSM-IV categories of PTSD (re-experiencing of the traumatic event, avoidance or numbing of responsiveness, including amnesia, and increased arousal) need to be asked.<sup>113, 114</sup> Affective, cognitive and behavioural symptoms should be described in detail, and the frequency, as well as examples, of nightmares, hallucinations and startle response should be stated. An absence of symptoms can be due to the episodic or often delayed nature of PTSD or to denial of symptoms because of shame.

#### (c) *Post-torture history*

278. This component of the psychological evaluation seeks information about current life circumstances. It is important to inquire about current sources of stress, such as separation or loss of loved ones, flight from the home country and life in exile. The interviewer should also inquire about the individual's ability to be productive, earn a living, care for his or her family and the availability of social supports.

#### (d) *Pre-torture history*

279. If relevant, describe the victim's childhood, adolescence, early adulthood, his or her family background, family illnesses and family composition. There should also be a description of the victim's educational and occupational history. Describe any history of past trauma, such as childhood abuse, war trauma or domestic violence, as well as the victim's cultural and religious background.

280. The description of pre-trauma history is important to assess mental health status and level of psychosocial functioning of the torture victim prior to the traumatic events. In this way, the interviewer can compare the current mental health status with that of the individual before torture. In evaluating background information, the interviewer should keep in mind that the duration and severity of responses to trauma are affected by multiple factors. These factors include, but are not limited to, the circumstances of the torture, the perception and interpretation of torture by the victim, the social context before, during and after torture, community and peer resources and values and attitudes about traumatic experiences, political and

<sup>113</sup> B. O. Rothbaum and others, "A prospective examination of post-traumatic stress disorder in rape victims", *Journal of Traumatic Stress*, vol. 5 (1992), pp. 455-475.

<sup>114</sup> P. B. Sutker and others, "Cognitive deficits and psychopathology among former prisoners of war and combat veterans of the Korean conflict", *American Journal of Psychiatry*, vol. 148 (1991), pp. 62-72.

cultural factors, severity and duration of the traumatic events, genetic and biological vulnerabilities, developmental phase and age of the victim, prior history of trauma and pre-existing personality. In many interview situations, because of time limitations and other problems, it may be difficult to obtain this information. It is important, nonetheless, to obtain enough data about the individual's previous mental health and psychosocial functioning to form an impression of the degree to which torture has contributed to psychological problems.

(e) *Medical history*

281. The medical history summarizes pre-trauma health conditions, current health conditions, body pain, somatic complaints, use of medication and its side effects, relevant sexual history, past surgical procedures and other medical data (see chapter V, sect. B).

(f) *Psychiatric history*

282. Inquiries should be made about a history of mental or psychological disturbances, the nature of problems and whether they received treatment or required psychiatric hospitalization. The inquiry should also cover prior therapeutic use of psychotropic medication.

(g) *Substance use and abuse history*

283. The clinician should inquire about substance use before and after the torture, changes in the pattern of use and whether substances are being used to cope with insomnia or psychological/psychiatric problems. These substances are not only alcohol, cannabis and opium but also regional substances of abuse such as betel nut and many others.

(h) *Mental status examination*

284. The mental status examination begins the moment the clinician meets the subject. The interviewer should make note of the person's appearance, such as signs of malnutrition, lack of cleanliness, changes in motor activity during the interview, use of language, presence of eye contact, ability to relate to the interviewer and the means the individual uses to establish communication. The following components should be covered, and all aspects of the mental status examination should be included in the report of the psychological evaluation; aspects such as general appearance, motor activity, speech, mood and affect, thought content, thought process, suicidal and homicidal ideation and a cognitive examination (orientation, long-term memory, intermediate recall and immediate recall).

(i) *Assessment of social function*

285. Trauma and torture can directly and indirectly affect a person's ability to function. Torture can also indirectly cause loss of functioning and disability, if the psychological consequences of the experience impair the individual's ability to care for himself or herself, earn a living, support a family and pursue an education. The clinician should assess the individual's current level of functioning by inquiring about daily activities, social role (as housewife, student, worker), social and recreational activ-

ities and perception of health status. The interviewer should ask the individual to assess his or her own health condition, to state the presence or absence of feelings of chronic fatigue and to report potential changes in overall functioning.

(j) *Psychological testing and the use of checklists and questionnaires*

286. Little published data exist on the use of psychological testing (projective and objective personality tests) in the assessment of torture survivors. Also, psychological tests of personality lack cross-cultural validity. These factors combine to limit severely the utility of psychological testing in the evaluation of torture victims. Neuropsychological testing may, however, be helpful in assessing cases of brain injury resulting from torture (see section C.4 below). An individual who has survived torture may have trouble expressing in words his or her experiences and symptoms. In some cases, it may be helpful to use trauma event and symptom checklists or questionnaires. If the interviewer believes it may be helpful to use these, there are numerous questionnaires available, although none are specific to torture victims.

(k) *Clinical impression*

287. In formulating a clinical impression for the purposes of reporting psychological evidence of torture, the following important questions should be asked:

- (i) Are the psychological findings consistent with the alleged report of torture?
- (ii) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
- (iii) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where is the individual in the course of recovery?
- (iv) What are the coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role)? What impact do these issues have on the individual?
- (v) Which physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture or detention;
- (vi) Does the clinical picture suggest a false allegation of torture?

288. Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged abuse. The emotional state and expression of the person during the interview, his or her symptoms, the history of detention and torture and the personal history prior to torture should be described. Factors such as the onset of specific symptoms related to the trauma, the specificity of any particular psychological findings and patterns of psychological functioning should be noted. Additional factors should be considered, such as forced migration, resettlement, difficulty of acculturation, language problems, unemployment, loss of home, family and social status. The relation-

ship and consistency between events and symptoms should be evaluated and described. Physical conditions, such as head trauma or brain injury, may require further evaluation. Neurological or neuropsychological assessment may be recommended.

289. If the survivor has symptom levels consistent with a DSM-IV or ICD-10 psychiatric diagnosis, the diagnosis should be stated. More than one diagnosis may be applicable. Again, it must be stressed that even though a diagnosis of a trauma-related mental disorder supports the claim of torture, not meeting criteria for a psychiatric diagnosis does not mean the person was not tortured. A survivor of torture may not have the level of symptoms required to meet diagnostic criteria for a DSM-IV or ICD-10 diagnosis fully. In these cases, as with all others, the symptoms that the survivor has and the torture story that he or she claims to have experienced should be considered as a whole. The degree of consistency between the torture story and the symptoms that the individual reports should be evaluated and described in the report.

290. It is important to recognize that some people falsely allege torture for a range of reasons and that others may exaggerate a relatively minor experience for personal or political reasons. The investigator must always be aware of these possibilities and try to identify potential reasons for exaggeration or fabrication. The clinician should keep in mind, however, that such fabrication requires detailed knowledge about trauma-related symptoms that individuals rarely possess. Inconsistencies in testimony can occur for a number of valid reasons, such as memory impairment due to brain injury, confusion, dissociation, cultural differences in perception of time or fragmentation and repression of traumatic memories. Effective documentation of psychological evidence of torture requires clinicians to have a capacity to evaluate consistencies and inconsistencies in the report. If the interviewer suspects fabrication, additional interviews should be scheduled to clarify inconsistencies in the report. Family or friends may be able to corroborate details of the story. If the clinician conducts additional examinations and still suspects fabrication, the clinician should refer the individual to another clinician and ask for the colleague's opinion. The suspicion of fabrication should be documented with the opinion of two clinicians.

#### (1) *Recommendations*

291. The recommendations resulting from the psychological evaluation depend on the question posed at the time the evaluation was requested. The issues under consideration may concern legal and judicial matters, asylum, resettlement or a need for treatment. Recommendations can be for further assessment, such as neuropsychological testing, medical or psychiatric treatment, or a need for security or asylum.

#### 4. *Neuropsychological assessment*

292. Clinical neuropsychology is an applied science concerned with the behavioural expression of brain dysfunction. Neuropsychological assessment, in particular, is concerned with the measurement and classification of behavioural disturbances associated with organic brain

impairment. The discipline has long been recognized as useful in discriminating between neurological and psychological conditions and in guiding treatment and rehabilitation of patients suffering from the consequences of various levels of brain damage. Neuropsychological evaluations of torture survivors are performed infrequently and to date there are no neuropsychological studies of torture survivors available in the literature. The following remarks are, therefore, limited to a discussion of general principles to guide health providers in understanding the utility of, and indications for, neuropsychological assessment of subjects suspected of being tortured. Before discussing the issues of utility and indications, it is essential to recognize the limitations of neuropsychological assessment in this population.

#### (a) *Limitations of neuropsychological assessment*

293. There are a number of common factors complicating the assessment of torture survivors in general that are outlined elsewhere in this manual. These factors apply to neuropsychological assessment in the same way as to a medical or psychological examination. Neuropsychological assessments may be limited by a number of additional factors, including lack of research on torture survivors, reliance on population-based norms, cultural and linguistic differences and re-traumatization of those who have experienced torture.

294. As mentioned above, very few references exist in the literature concerning the neuropsychological assessment of torture victims. The pertinent body of literature concerns various types of head trauma and the neuropsychological assessment of PTSD in general. Therefore, the following discussion and subsequent interpretations of neuropsychological assessments are necessarily based on the application of general principles used with other subject populations.

295. Neuropsychological assessment as it has been developed and practised in Western countries relies heavily on an actuarial approach. This approach typically involves comparing the results of a battery of standardized tests to population-based norms. Although norm-referenced interpretations of neuropsychological assessments may be supplemented by a Lurian approach of qualitative analysis, particularly when the clinical situation demands it, a reliance on the actuarial approach predominates.<sup>115, 116</sup> Moreover, a reliance on test scores is greatest when brain impairment is mild to moderate in severity, rather than severe, or when neuropsychological deficits are thought to be secondary to a psychiatric disorder.

296. Cultural and linguistic differences may significantly limit the utility and applicability of neuropsychological assessment among suspected torture victims. Neuropsychological assessments are of questionable validity when standard translations of tests are unavailable and the clinical examiner is not fluent in the subject's

<sup>115</sup> A. R. Luria and L. V. Majovski, "Basic approaches used in American and Soviet clinical neuropsychology", *American Psychologist*, vol. 32 (11) (1977), pp. 959-968.

<sup>116</sup> R. J. Ivnik, "Overstatement of differences", *American Psychologist*, vol. 33 (8) (1978), pp. 766-767.

language. Unless standardized translations of tests are available and examiners are fluent in the subject's language, verbal tasks cannot be administered at all and cannot be interpreted in a meaningful way. This means that only non-verbal tests can be used, and this precludes comparison between verbal and non-verbal faculties. In addition, an analysis of the lateralization (or localization) of deficits is more difficult. This analysis is often useful, however, because of the brain's asymmetrical organization, with the left hemisphere typically being dominant for speech. If population-based norms are unavailable for the subject's cultural and linguistic group, neuropsychological assessment is also of questionable validity. An estimate of IQ is one of the central benchmarks that allow examiners to place neuropsychological test scores into proper perspective. Within the population of the United States, for example, these estimates are often derived from verbal subsets using the Wechsler scales, particularly the information subscale, because in the presence of organic brain impairment, acquired factual knowledge is less likely to suffer deterioration than other tasks and be more representative of past learning ability than other measures. Measurement may also be based on educational and work history and demographic data. Obviously, neither one of these two considerations applies to subjects for whom population-based norms have not been established. Therefore, only very coarse estimates concerning pre-trauma intellectual functioning can be made. As a result, neuropsychological impairment that is anything less than severe or moderate may be difficult to interpret.

297. Neuropsychological assessments may re-traumatize those who have experienced torture. Great care must be taken in order to minimize any potential re-traumatization of the subject in any form of diagnostic procedure (see chapter IV, sect. H). To cite only one obvious example specific to neuropsychological testing, it would be potentially very damaging to proceed with a standard administration of the Halstead-Reitan Battery, in particular the Tactual Performance Test (TPT), and routinely blindfold the subject. For most torture victims who have experienced blindfolding during detention and torture, and even for those who were not blindfolded, it would be very traumatic to introduce the experience of helplessness inherent in this procedure. In fact, any form of neuropsychological testing in itself may be problematic, regardless of the instrument used. Being observed, timed with a stopwatch and asked to give maximum effort on an unfamiliar task, in addition to being asked to perform, rather than having a dialogue, may prove to be too stressful or reminiscent of the torture experience.

#### (b) *Indications for neuropsychological assessment*

298. In evaluating behavioural deficits in suspected torture victims, there are two primary indications for neuropsychological assessment: brain injury and PTSD plus related diagnoses. While both sets of conditions overlap in some aspects, and will often coincide, it is only the former that is a typical and traditional application of clinical neuropsychology, whereas the latter is relatively new, not well researched and rather problematic.

299. Brain injury and resulting brain damage may result from various types of head trauma and metabolic disturbances inflicted during periods of persecution, detention and torture. This may include gunshot wounds, the effects of poisoning, malnutrition as a result of starvation or forced ingestion of harmful substances, the effects of hypoxia or anoxia resulting from asphyxiation or near drowning and, most commonly, from blows to the head suffered during beatings. Blows to the head are frequently inflicted during periods of detention and torture. For example, in one sample of torture survivors, blows to the head were the second most frequently cited form of bodily abuse (45 per cent) behind blows to the body (58 per cent).<sup>117</sup> The potential for brain damage is high among torture victims.

300. Closed head injuries resulting in mild to moderate levels of long-term impairment are perhaps the most commonly assessed cause of neuropsychological abnormality. While signs of injury may include scars on the head, brain lesions cannot usually be detected by diagnostic imaging of the brain. Mild to moderate levels of brain damage might be overlooked or underestimated by mental health professionals because symptoms of depression and PTSD are likely to figure prominently in the clinical picture, resulting in less attention being paid to the potential effect of head trauma. Commonly, the subjective complaints of survivors include difficulties with attention, concentration and short-term memory, which can be the result of either brain impairment or PTSD. Since these complaints are common in survivors suffering from PTSD, the question whether they are actually due to head injury may not even be asked.

301. The diagnostician must rely, in an initial phase of the examination, on reported history of head trauma and the course of symptomatology. As is usually the case with brain-injured subjects, information from third parties, particularly relatives, may prove helpful. It must be remembered that brain-injured subjects often have great difficulty articulating or even appreciating their limitations because they are, so to speak, "inside" the problem. In gathering first impressions regarding the difference between organic brain impairment and PTSD, an assessment concerning the chronicity of symptoms is a helpful starting point. If symptoms of poor attention, concentration and memory are observed to fluctuate over time and to co-vary with levels of anxiety and depression, this is more likely due to the phasic nature of PTSD. On the other hand, if impairment seems to appear chronic, lacks fluctuation and is confirmed by family members, the possibility of brain impairment should be entertained, even in the initial absence of a clear history of head trauma.

302. Once there is a suspicion of organic brain impairment, the first step for a mental health professional is to consider a referral to a physician for further neurological examination. Depending on initial findings, the physician may then consult a neurologist or order diagnostic tests. An extensive medical work-up, specific neurological consultation and neuropsychological evaluation

<sup>117</sup> H. C. Traue, G. Schwarz-Langer and N. F. Gurrus, "Extremtraumatisierung durch Folter: Die psychotherapeutische Arbeit der Behandlungszentren für Folteropfer", *Verhaltenstherapie und Verhaltensmedizin*, vol. 18 (1) (1997), pp. 41-62.

are among the possibilities to be considered. The use of neuropsychological evaluation procedures is usually indicated if there is a lack of gross neurological disturbance, reported symptoms are predominantly cognitive in nature or a differential diagnosis between brain impairment and PTSD has to be made.

303. The selection of neuropsychological tests and procedures is subject to the limitations specified above and, therefore, cannot follow a standard battery format, but rather must be case-specific and sensitive to individual characteristics. The flexibility required in the selection of tests and procedures demands considerable experience, knowledge and caution on the part of the examiner. As has been pointed out above, the range of instruments to be used will often be limited to non-verbal tasks, and the psychometric characteristics of any standardized tests will most likely suffer when population-based norms do not apply to an individual subject. An absence of verbal measures represents a very serious limitation. Many areas of cognitive functioning are mediated through language, and systematic comparisons between various verbal and non-verbal measures are typically used in order to arrive at conclusions regarding the nature of deficits.

304. What complicates matters further is evidence that significant inter-group differences in performances of non-verbal tasks have been found between relatively closely related cultures. For example, research compared the performance of randomly selected, community-based samples of 118 English-speaking and 118 Spanish-speaking elders on a brief neuropsychological test battery.<sup>118</sup> The samples were randomly selected and demographically matched. Yet, while scores on verbal measures were similar, the Spanish-speaking subjects scored significantly lower on almost all non-verbal measures. These results suggest that caution is warranted when using non-verbal and verbal measures to assess non-English-speaking individuals, when tests are prepared for English-speaking subjects.

305. The choice of instruments and procedures in neuropsychological assessment of suspected torture victims must be left to the individual clinician, who will have to select them in accordance with the demands and possibilities of the situation. Neuropsychological tests cannot be used properly without extensive training and knowledge in brain-behaviour relations. Comprehensive lists of neuropsychological procedures and tests and their proper application can be found in standard references.<sup>119</sup>

#### (c) *Post-traumatic stress disorder*

306. The considerations offered above should make it clear that great caution is needed when attempting neuropsychological assessment of brain impairment in suspected torture victims. This must be even more strongly

the case in attempting to document PTSD in suspected survivors through neuropsychological assessment. Even in the case of assessing PTSD subjects for whom population-based norms are available, there are considerable difficulties to consider. PTSD is a psychiatric disorder and traditionally has not been the focus of neuropsychological assessment. Furthermore, PTSD does not conform to the classical paradigm of an analysis of identifiable brain lesions that can be confirmed by medical techniques. With an increased emphasis on and understanding of the biological mechanisms involved in psychiatric disorders generally, neuropsychological paradigms have been invoked more frequently than in the past. However, as has been pointed out, "... comparatively little has been written to date on PTSD from a neuropsychological perspective".<sup>120</sup>

307. There is great variability among the samples used for the study of neuropsychological measures in post-traumatic stress. This may account for the variability of the cognitive problems reported from these studies. It was pointed out that "clinical observations suggest that PTSD symptoms show the most overlap with the neurocognitive domains of attention, memory and executive functioning". This is consistent with complaints heard frequently from survivors of torture. Subjects complain of difficulties in concentrating and feeling unable to retain information and engage in planned, goal-directed activity.

308. Neuropsychological assessment methods appear able to identify the presence of neurocognitive deficits in PTSD, even though the specificity of these deficits is more difficult to establish. Some studies have documented the presence of deficits in PTSD subjects when compared to normal controls but they have failed to discriminate these subjects from matched psychiatric controls.<sup>121, 122</sup> In other words, it is likely that neurocognitive deficits on test performances will be evident in cases of PTSD, but insufficient for diagnosing it. As in many other types of assessment, interpretation of test results must be integrated into a larger context of interview information and possibly personality testing. In that sense, specific neuropsychological assessment methods can make a contribution to the documentation of PTSD in the same manner that they do for other psychiatric disorders associated with known neurocognitive deficits.

309. Despite significant limitations, neuropsychological assessment may be useful in evaluating individuals suspected of having brain injury and in distinguishing brain injury from PTSD. Neuropsychological assessment may also be used to evaluate specific symptoms, such as problems with memory that occur in PTSD and related disorders.

<sup>120</sup> J. A. Knight, "Neuropsychological assessment in posttraumatic stress disorder", *Assessing Psychological Trauma and PTSD*, J. P. Wilson and T. M. Keane, eds. (New York, Guilford Press, 1997).

<sup>121</sup> J. E. Dalton, S. L. Pederson and J. J. Ryan, "Effects of post-traumatic stress disorder on neuropsychological test performance", *International Journal of Clinical Neuropsychology*, vol. 11 (3) (1989), pp. 121-124.

<sup>122</sup> T. Gil and others, "Cognitive functioning in post-traumatic stress disorder", *Journal of Traumatic Stress*, vol. 3, No. 1 (1990), pp. 29-45.

<sup>118</sup> D. M. Jacobs and others, "Cross-cultural neuropsychological assessment: a comparison of randomly selected, demographically matched cohorts of English and Spanish-speaking older adults", *Journal of Clinical and Experimental Neuropsychology*, vol. 19 (No. 3) (1997), pp. 331-339.

<sup>119</sup> O. Spreen and E. Strauss, *A Compendium of Neuropsychological Tests*, 2nd ed. (New York, Oxford University Press, 1998).

## 5. *Children and torture*

310. Torture can impact a child directly or indirectly. The impact can be due to the child's having been tortured or detained, the torture of parents or close family members or witnessing torture and violence. When individuals in a child's environment are tortured, the torture will inevitably have an impact on the child, albeit indirect, because torture affects the entire family and community of torture victims. A complete discussion of the psychological impact of torture on children and complete guidelines for conducting an evaluation of a child who has been tortured is beyond the scope of this manual. Nevertheless, several important points can be summarized.

311. First, when evaluating a child who is suspected of having undergone or witnessed torture, the clinician must make sure that the child receives support from caring individuals and that he or she feels secure during the evaluation. This may require a parent or trusted care provider to be present during the evaluation. Second, the clinician must keep in mind that children do not often express their thoughts and emotions regarding trauma verbally, but rather behaviourally.<sup>123</sup> The degree to which children are able to verbalize thought and affect depends on the child's age, developmental level and other factors, such as family dynamics, personality characteristics and cultural norms.

312. If a child has been physically or sexually assaulted, it is important, if at all possible, for the child to be seen by an expert in child abuse. Genital examination of children, likely to be experienced as traumatic, should be performed by clinicians experienced in interpreting the findings. Sometimes it is appropriate to videotape the examination so that other experts can give opinions on the physical findings without the child having to be examined again. It may be inappropriate to perform a full genital or anal examination without a general anaesthetic. Furthermore, the examiner should be aware that the examination itself may be reminiscent of the assault and it is possible that the child may make a spontaneous outcry or psychologically decompensate during the examination.

### (a) *Developmental considerations*

313. A child's reactions to torture depend on age, developmental stage and cognitive skills. The younger the child, the more his or her experience and understanding of the traumatic event will be influenced by the immediate reactions and attitudes of caregivers following the event.<sup>124</sup> For children under the age of three who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial.<sup>125</sup> The reactions of very young children to traumatic experiences

typically involve hyperarousal, such as restlessness, sleep disturbance, irritability, heightened startle reactions and avoidance. Children over three often tend to withdraw and refuse to speak directly about traumatic experiences. The ability for verbal expression increases during development. A marked increase occurs around the concrete operational stage (8-9 years old), when children develop the ability to provide a reliable chronology of events. During this stage, concrete operations and temporal and spatial capacities develop.<sup>126</sup> These new skills are still fragile, and it is not usually until the beginning of the formal operational stage (12 years old) that children are consistently able to construct a coherent narrative. Adolescence is a turbulent developmental period. The effects of torture can vary widely. Torture experiences may cause profound personality changes in adolescents resulting in antisocial behaviour.<sup>127</sup> Alternatively, the effects of torture on adolescents may be similar to those seen in younger children.

### (b) *Clinical considerations*

314. Symptoms of PTSD may appear in children. The symptoms can be similar to those observed in adults, but the clinician must rely more heavily on observations of the child's behaviour than on verbal expression.<sup>128, 129, 130, 131</sup> For example, the child may demonstrate symptoms of re-experiencing as manifested by monotonous, repetitive play representing aspects of the traumatic event, visual memories of the events in and out of play, repeated questions or declarations about the traumatic event and nightmares. The child may develop bed-wetting, loss of control of bowel movements, social withdrawal, restricted affect, attitude changes towards self and others and feelings that there is no future. He or she may experience hyperarousal and have night terrors, problems going to bed, sleep disturbance, heightened startle response, irritability and significant disturbances in attention and concentration. Fears and aggressive behaviour that were non-existent before the traumatic event may appear as aggressiveness towards peers, adults or animals, fear of the dark, fear of going to the toilet alone and phobias. The child may demonstrate sexual behaviour that is inappropriate for his or her age and somatic reactions. Anxiety symptoms, such as exaggerated fear of strangers, separation anxiety, panic, agitation, temper tantrums and uncontrolled crying may appear. The child may also develop eating problems.

### (c) *Role of the family*

315. The family plays an important dynamic role in persisting symptomatology among children. In order to preserve cohesion in the family, dysfunctional behaviours

<sup>123</sup> C. Schlar, "Evaluation and documentation of psychological evidence of torture", unpublished paper, 1999.

<sup>124</sup> S. von Overbeck Ottino, "Familles victimes de violences collectives et en exil : quelle urgence, quel modèle de soins ? Le point de vue d'une pédopsychiatre", *Revue française de psychiatrie et de psychologie médicale*, vol. 14 (1998), pp. 35-39.

<sup>125</sup> V. Grappe, "La guerre en ex-Yougoslavie: un regard sur les enfants réfugiés", *Psychiatrie humanitaire en ex-Yougoslavie et en Arménie. Face au traumatisme*, M. R. Moro and S. Lebovici, eds. (Paris, Presses universitaires de France, 1995).

<sup>126</sup> J. Piaget, *La naissance de l'intelligence chez l'enfant* (Neuchâtel, Delachaux et Niestlé, 1977).

<sup>127</sup> See footnote 125.

<sup>128</sup> L. C. Terr, "Childhood traumas: an outline and overview", *American Journal of Psychiatry*, vol. 148 (1991), pp. 10-20.

<sup>129</sup> National Center for Infants, Toddlers and Families, *Zero to Three* (1994).

<sup>130</sup> F. Sironi, "On torture un enfant, ou les avatars de l'ethnocentrisme psychologique", *Enfances*, No. 4 (1995), pp. 205-215.

<sup>131</sup> L. Bailly, *Les catastrophes et leurs conséquences psychotraumatiques chez l'enfant* (Paris, ESF, 1996).



and delegation of roles may occur. Family members, often children, can be assigned the role of patient and develop severe disorders. A child may be overly protected or important facts about the trauma may be hidden. Alternatively, the child can be parentified and expected to care for the parents. When the child is not the direct victim of torture but only indirectly affected, adults often tend to underestimate the impact on the child's psyche and devel-

opment. When loved ones around a child have been persecuted, raped and tortured or the child has witnessed severe trauma or torture, he or she may develop dysfunctional beliefs such as that he or she is responsible for the bad events or that he or she has to bear the parent's burdens. This type of belief can lead to long-term problems with guilt, loyalty conflicts, personal development and maturing into an independent adult.

## ANNEX I

**Principles on the Effective Investigation and Documentation  
of Torture and Other Cruel, Inhuman or Degrading  
Treatment or Punishment\***

1. The purposes of effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (hereinafter “torture or other ill-treatment”) include the following:

(a) Clarification of the facts and establishment and acknowledgement of individual and State responsibility for victims and their families;

(b) Identification of measures needed to prevent recurrence;

(c) Facilitation of prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible and demonstration of the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.

2. States shall ensure that complaints and reports of torture or ill-treatment are promptly and effectively investigated. Even in the absence of an express complaint, an investigation shall be undertaken if there are other indications that torture or ill-treatment might have occurred. The investigators, who shall be independent of the suspected perpetrators and the agency they serve, shall be competent and impartial. They shall have access to, or be empowered to commission investigations by, impartial medical or other experts. The methods used to carry out such investigations shall meet the highest professional standards and the findings shall be made public.

3. (a) The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry.<sup>a</sup> The persons conducting the investigation shall have at their disposal all the necessary budgetary and technical resources for effective investigation. They shall also have the authority to oblige all those acting in an official capacity allegedly involved in torture or ill-treatment to appear and testify. The same shall apply to any witness. To this end, the investigative authority shall be entitled to issue summonses to witnesses, including any officials allegedly involved, and to demand the production of evidence.

(b) Alleged victims of torture or ill-treatment, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture or ill-treatment shall be removed from any position of control or power, whether direct or indirect, over complainants, witnesses and their families, as well as those conducting the investigation.

4. Alleged victims of torture or ill-treatment and their legal representatives shall be informed of, and have access to, any hearing, as well as to all information relevant to the investigation, and shall be entitled to present other evidence.

5. (a) In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse or for other substantial reasons, States shall ensure that investiga-

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\* The Commission on Human Rights, in its resolution 2000/43, and the General Assembly, in its resolution 55/89, drew the attention of Governments to the Principles and strongly encouraged Governments to reflect upon the Principles as a useful tool in efforts to combat torture.

<sup>a</sup> Under certain circumstances, professional ethics may require information to be kept confidential. These requirements should be respected.

tions are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these Principles.<sup>b</sup>

(b) A written report, made within a reasonable time, shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. Upon completion, the report shall be made public. It shall also describe in detail specific events that were found to have occurred and the evidence upon which such findings were based and list the names of witnesses who testified, with the exception of those whose identities have been withheld for their own protection. The State shall, within a reasonable period of time, reply to the report of the investigation and, as appropriate, indicate steps to be taken in response.

6. (a) Medical experts involved in the investigation of torture or ill-treatment shall behave at all times in conformity with the highest ethical standards and, in particular, shall obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations shall be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials.

(b) The medical expert shall promptly prepare an accurate written report, which shall include at least the following:

- (i) Circumstances of the interview: name of the subject and name and affiliation of those present at the examination; exact time and date; location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g., detention centre, clinic or house); circumstances of the subject at the time of the examination (e.g., nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner or threatening statements to the examiner); and any other relevant factors;
- (ii) History: detailed record of the subject's story as given during the interview, including alleged methods of torture or ill-treatment, times when torture or ill-treatment is alleged to have occurred and all complaints of physical and psychological symptoms;
- (iii) Physical and psychological examination: record of all physical and psychological findings on clinical examination, including appropriate diagnostic tests and, where possible, colour photographs of all injuries;
- (iv) Opinion: interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment. A recommendation for any necessary medical and psychological treatment and/or further examination shall be given;
- (v) Authorship: the report shall clearly identify those carrying out the examination and shall be signed.

(c) The report shall be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process shall be solicited and recorded in the report. It shall also be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill-treatment. It is the responsibility of the State to ensure that it is delivered securely to these persons. The report shall not be made available to any other person, except with the consent of the subject or on the authorization of a court empowered to enforce such a transfer.

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<sup>b</sup> See footnote (a) above.

## ANNEX II

**Diagnostic tests**

Diagnostic tests are being developed and evaluated all the time. The following tests were considered to be of value at the time of writing of this manual. However, when additional supporting evidence is required, investigators should attempt to find up-to-date sources of information, for example by approaching one of the specialized centres for the documentation of torture (see chapter V, sect. E).

1. *Radiological imaging*

In the acute phase of injury, various imaging modalities may be quite useful in providing additional documentation of skeletal and soft tissue injury. Once the physical injuries of torture have healed, however, the residual sequelae are generally no longer detectable by the same imaging methods. This is often true even when the survivor continues to suffer significant pain or disability from his or her injuries. Reference has already been made to various radiological studies in the discussion of the examination of the patient or in the context of various forms of torture. The following is a summary of the application of these methods. However, the more sophisticated and expensive technology is not universally available or at least not to a person in custody.

Radiological and imaging diagnostic examinations include routine radiographs (X-rays), radioisotopic scintigraphy, computerized tomography (CT), nuclear magnetic resonance imaging (MRI) and ultrasonography (USG). Each has advantages and disadvantages. X-rays, scintigraphy and CT use ionizing radiation, which may be a concern in cases of pregnant women and children. MRI uses a magnetic field. Potential biologic effects on foetuses and children are theoretical, but thought to be minimal. Ultrasound uses sound waves, and no biologic risk is known.

X-rays are readily available. Excluding the skull, all injured areas should have routine radiographs as the initial examination. While routine radiographs will demonstrate facial fractures, CT is a superior examination as it demonstrates more fractures, fragment displacement and associated soft tissue injury and complications. When periosteal damage or minimal fractures are suspected, bone scintigraphy should be used in addition to X-rays. A percentage of X-rays will be negative even when there is an acute fracture or early osteomyelitis. It is possible for a fracture to heal, leaving no radiographic evidence of previous injury. This is especially true in children. Routine radiographs are not the ideal examination for evaluation of soft tissue.

Scintigraphy is an examination of high sensitivity, but low specificity. It is an inexpensive and effective examination used to screen the entire skeleton for disease processes such as osteomyelitis or trauma. Testicular torsion can also be evaluated, but ultrasound is better suited to this task. Scintigraphy is not a method to identify soft tissue trauma. Scintigraphy can detect an acute fracture within 24 hours, but it generally takes two to three days and may occasionally take a week or more, particularly in the case of the elderly. The scan generally returns to normal after two years. However, it may remain positive for years in cases of fractures and cured osteomyelitis. The use of bone scintigraphy to detect fractures at the epiphysis or metadiaphysis (ends of long bones) in children is very difficult because of the normal uptake of the radio-pharmaceutical at the epiphysis. Scintigraphy is often able to detect rib fractures that are not apparent on routine X-ray films.

(a) *Application of bone scintigraphy to the diagnosis of falanga*

Bone scans can be performed either with delayed images at about three hours or as a three-phase examination. The three phases are the radionuclide angiogram (arterial phase), blood pool images (venous phase, which is soft tissue) and delayed phase (bone phase). Patients examined soon after *falanga* should have two bone scans performed at one-week intervals. A negative first delayed scan and positive second scan indicate exposure to *falanga* within days before the first scan. In acute cases, two negative bone scans at an interval of one week do not necessarily mean that *falanga* did not occur, but that the severity of the *falanga* applied was below the sensitivity level of the scintigraphy. Initially, if three-phase scanning is done, increased uptake in the radionuclide angiogram phase and the blood pool images and no increase uptake in the bone phase would indicate hyperaemia compatible with soft tissue injury. Trauma in the foot bones and soft tissue can also be detected with MRI.<sup>a</sup>

(b) *Ultrasound*

Ultrasound is inexpensive and without biological hazard. The quality of an examination depends on the skill of the operator. Where CT is not available, ultrasound is used to evaluate acute abdominal trauma. Tendonopathy can also be evaluated by ultrasound, and it is a method of choice for testicular abnormalities. Shoulder ultrasound is carried out in the acute and chronic periods following

<sup>a</sup> See chapter V, footnotes 76 and 83; also refer to standard radiology and nuclear medicine texts for further information.

suspension torture. In the acute period, oedema, fluid collection on and around the shoulder joint, lacerations and haematomas of the rotator cuffs can be observed by ultrasound. Re-examination with ultrasound and finding that the evidence in the acute period disappears over time strengthen the diagnosis. In such cases, MRI, scintigraphy and other radiological examinations should be carried out together, and their correlation should be examined. Even without positive results from other examinations, ultrasound findings alone are adequate to prove suspension torture.

### (c) *Computerized tomography*

CT is excellent for imaging soft tissue and bone. However, MRI is better for soft tissue than bone. MRI may detect an occult fracture before it can be imaged by either routine radiographs or scintigraphy. Use of open scanners and sedation may alleviate anxiety and claustrophobia, which are prevalent among torture survivors. CT is also excellent for diagnosing and evaluating fractures, especially temporal and facial bones. Other advantages include alignment and displacement of fragments, especially spinal, pelvic, shoulder and acetabular fractures. It cannot identify bone bruising. CT with and without intravenous infusion of a contrast agent should be the initial examination for acute, sub-acute and chronic central nervous system (CNS) lesions. If the examination is negative, equivocal or does not explain the survivor's CNS complaints or symptoms, proceed to MRI. CT with bone windows and a pre- and post-contrast examination should be the initial examination for temporal bone fractures. Bone windows may demonstrate fractures and ossicular disruption. The pre-contrast examination may demonstrate fluid and cholesteatoma. Contrast is recommended because of the common vascular anomalies that occur in this area. For rhinorrhea, injection of a contrast agent into the spinal canal should follow a temporal bone. MRI may also demonstrate the tear responsible for leakage of the fluid. When rhinorrhea is suspected, a CT of the face with soft tissue and bone windows should be performed. Then a CT should be obtained after a contrast agent is injected into the spinal canal.

### (d) *Magnetic resonance imaging*

MRI is more sensitive than CT in detecting CNS abnormalities. The time course of CNS haemorrhage is divided into immediate, hyperacute, acute, sub-acute and chronic phases and CNS haemorrhage has ranges that correlate with imaging characteristics of the haemorrhage. Thus, the imaging findings may allow estimation of the timing of head injuries and correlation to alleged incidents. CNS haemorrhage may completely resolve or produce sufficient haemosiderin deposits for the CT to be positive even years later. Haemorrhage in soft tissue, especially in muscle, usually resolves completely, leaving no trace, but, in rare cases, it can ossify. This is called heterotrophic bone formation or *Myositis ossificans* and is detectable with CT.

## 2. *Biopsy of electric shock injury*

Electric shock injuries may, but do not necessarily, exhibit microscopic changes that are highly diagnostic

and specific for electric current trauma. Absence of these specific changes in a biopsy specimen does not mitigate against a diagnosis of electric shock torture, and judicial authorities must not be permitted to make such an assumption. Unfortunately, if a court requests a petitioner alleging electric shock torture to submit to a biopsy for confirmation of the allegations, refusal to consent to the procedure or a negative result is bound to have a prejudicial impact on the court. Furthermore, clinical experience with biopsy diagnosis of torture-related electrical injury is limited, and the diagnosis can usually be made with confidence from the history and physical examination alone.

This procedure is, therefore, one that should be done in a clinical research setting and not promoted as a diagnostic standard. In giving informed consent for biopsy, the person must be informed of the uncertainty of the results and permitted to weigh the potential benefit against the impact upon an already traumatized psyche.

### (a) *Rationale for biopsy*

There has been extensive laboratory research measuring the effects of electric shocks on the skin of anaesthetized pigs.<sup>b,c,d,e,f,g</sup> This work has shown that there are histologic findings specific to electrical injury that can be established by microscopic examination of punch biopsies of the lesions. However, further discussion of this research, which may have significant clinical application, is beyond the scope of this publication. The reader is referred to the footnote references for additional information.

Few cases of electric shock torture of humans have been studied histologically.<sup>h,i,j,k</sup> Only in one case, where

<sup>b</sup> H. K. Thomsen and others, "Early epidermal changes in heat and electrically injured pigskin: a light microscopic study", *Forensic Science International*, vol. 17 (1981), pp. 133-143.

<sup>c</sup> Ibid., "The effect of direct current, sodium hydroxide and hydrochloric acid on pig epidermis: a light microscopic and electron microscopic study", *Acta Pathol. Microbiol. Immunol. Scand*, vol. 91 (1983), pp. 307-316.

<sup>d</sup> H. K. Thomsen, "Electrically induced epidermal changes: a morphological study of porcine skin after transfer of low-moderate amounts of electrical energy", dissertation (University of Copenhagen, F.A.D.L., 1984), pp. 1-78.

<sup>e</sup> T. Karlsmark and others, "Tracing the use of torture: electrically induced calcification of collagen in pigskin", *Nature*, vol. 301 (1983), pp. 75-78.

<sup>f</sup> Ibid., "Electrically induced collagen calcification in pigskin: a histopathologic and histochemical study", *Forensic Science International*, vol. 39 (1988), pp. 163-174.

<sup>g</sup> T. Karlsmark, "Electrically induced dermal changes: a morphological study of porcine skin after transfer of low to moderate amounts of electrical energy", dissertation, University of Copenhagen, *Danish Medical Bulletin*, vol. 37 (1990), pp. 507-520.

<sup>h</sup> L. Danielsen and others, "Diagnosis of electrical skin injuries: a review and a description of a case", *American Journal of Forensic Medical Pathology*, vol. 12 (1991), pp. 222-226.

<sup>i</sup> F. Öztö and others, "Signs of electrical torture on the skin", *Treatment and Rehabilitation Center Report 1994* (Human Rights Foundation of Turkey), vol. 11 (1994), pp. 97-104.

<sup>j</sup> L. Danielsen, T. Karlsmark, H. K. Thomsen, "Diagnosis of skin lesions following electrical torture", *Rom. J. Leg. Med.*, vol. 5 (1997), pp. 15-20.

<sup>k</sup> H. Jacobsen, "Electrically induced deposition of metal on the human skin", *Forensic Science International*, vol. 90 (1997), pp. 85-92.

lesions were probably excised seven days after the injury, were alterations in the skin believed to be diagnostic of the electrical injuries observed (deposition of calcium salts on dermal fibres in viable tissue located around necrotic tissue). Lesions excised a few days after alleged electrical torture in other cases have shown segmental changes and deposits of calcium salts on cellular structures highly consistent with the influence of an electrical current, but they are not diagnostic since deposits of calcium salts on dermal fibres were not observed. A biopsy taken one month after alleged electrical torture showed a conical scar, 1-2 millimetres wide, with an increased number of fibroblasts and tightly packed, thin collagen fibres, arranged parallel to the surface, consistent with but not diagnostic of electrical injury.

(b) *Method*

After receiving informed consent from the patient, and before biopsy, the lesion must be photographed using accepted forensic methods. Under local anaesthesia, a 3-4 millimetre punch biopsy is obtained, and placed in buffered formalin or a similar fixative. Skin biopsy should be performed as soon as possible after injury. Since electrical trauma is usually confined to the epidermis and superficial dermis, the lesions may quickly disappear. Biopsies can be taken from more than one lesion, but the potential distress to the patient must be taken into ac-

count.<sup>1</sup> Biopsy material should be examined by a pathologist experienced in dermatopathology.

(c) *Diagnostic findings for electrical injury*

Diagnostic findings for electrical injury include vesicular nuclei in epidermis, sweat glands and vessel walls (only one differential diagnosis: injuries via basic solutions) and deposits of calcium salts distinctly located on collagen and elastic fibres (the differential diagnosis, *Calcinosis cutis*, is a rare disorder only found in 75 of 220,000 consecutive human skin biopsies, and the calcium deposits are usually massive without distinct location on collagen and elastic fibres).<sup>m</sup>

Typical, but not diagnostic, findings for electrical injury are lesions appearing in conical segments, often 1-2 millimetres wide, deposits of iron or copper on epidermis (from the electrode) and homogenous cytoplasm in epidermis, sweat glands and vessel walls. There may also be deposits of calcium salts on cellular structures in segmental lesions or no abnormal histologic observations.

<sup>1</sup> S. Gürpınar and S. Korur Fincancı, "İnsan Hakları İhlalleri ve Hekim Sorumluluğu" (Human rights violations and responsibility of the physician), *Birinci Basamak İçin Adli Tıp El Kitabı* (Handbook of Forensic Medicine for General Practitioners) (Ankara, Turkish Medical Association, 1999).

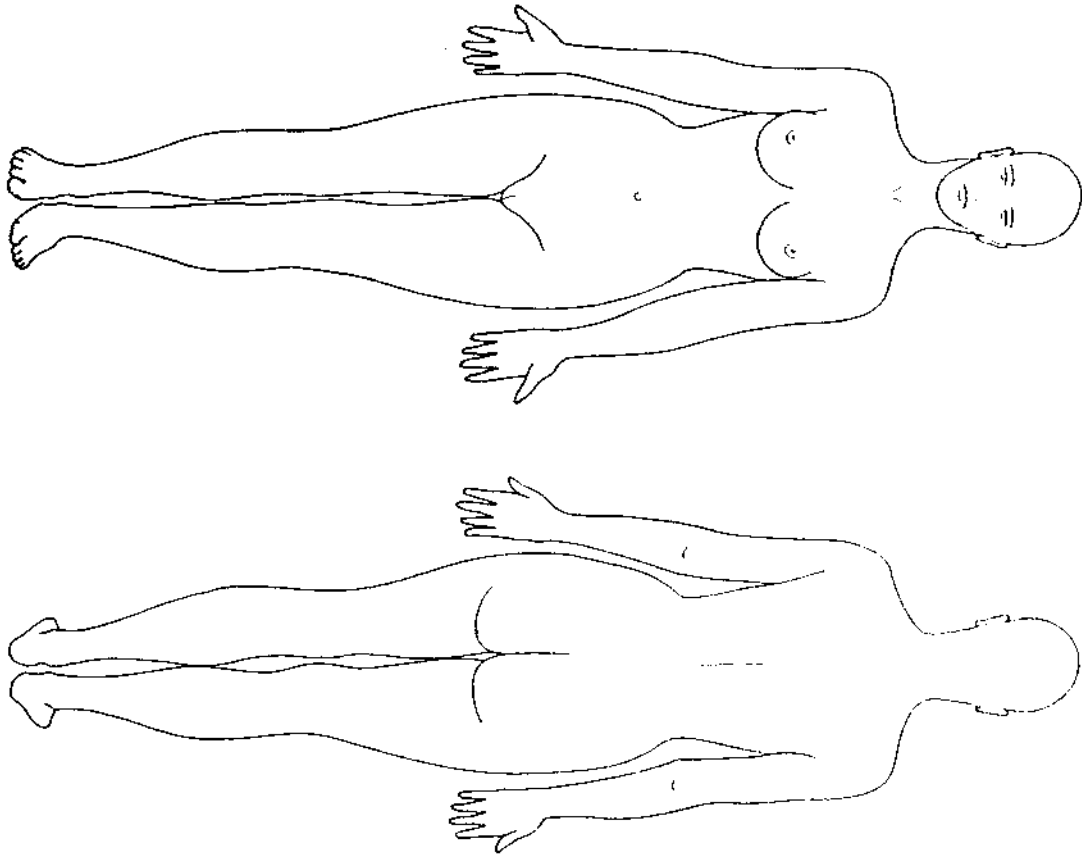
<sup>m</sup> See footnote (h) above.



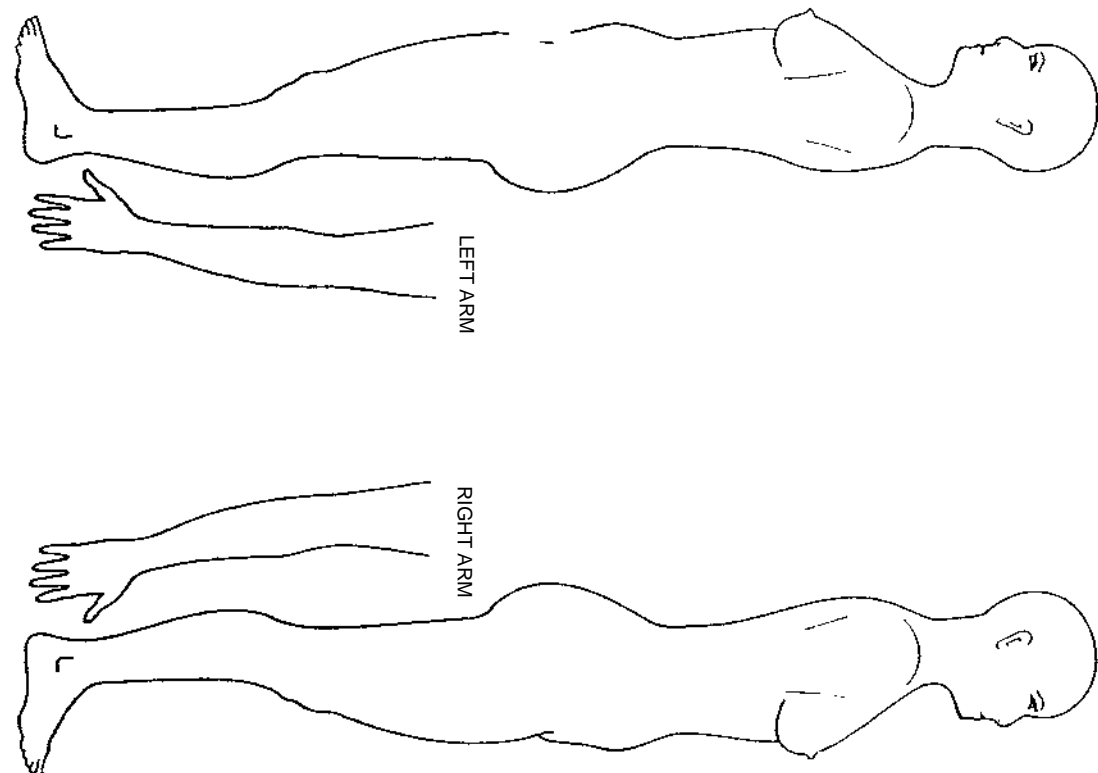
ANNEX III

Anatomical drawings for documentation of torture and ill-treatment

FULL BODY, FEMALE—ANTERIOR AND POSTERIOR VIEWS



FULL BODY, FEMALE—LATERAL VIEW



Name \_\_\_\_\_

Case No. \_\_\_\_\_

Date \_\_\_\_\_

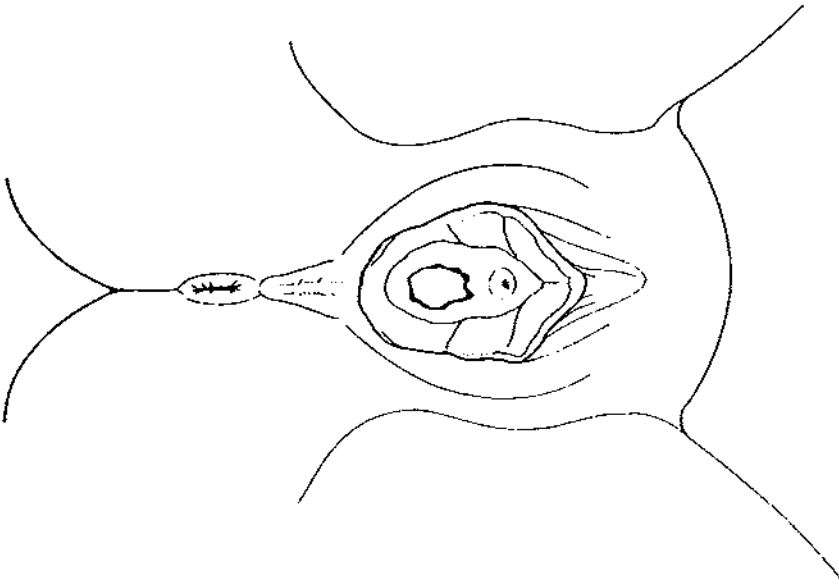
Name \_\_\_\_\_

Case No. \_\_\_\_\_

Date \_\_\_\_\_



PERINEUM—FEMALE

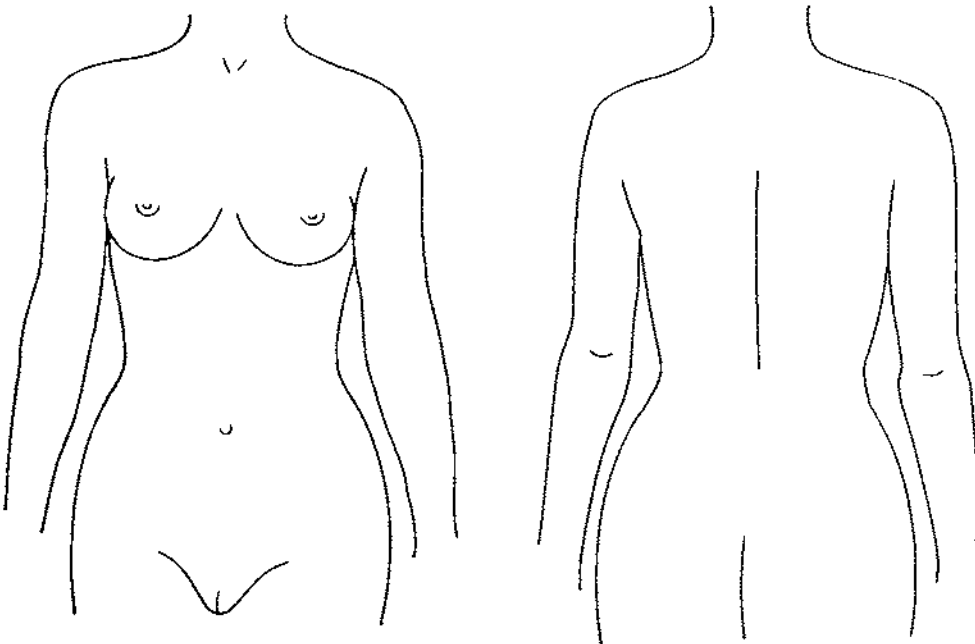


Name \_\_\_\_\_

Case No. \_\_\_\_\_

Date \_\_\_\_\_

THORACIC ABDOMINAL, FEMALE—ANTERIOR AND POSTERIOR VIEWS

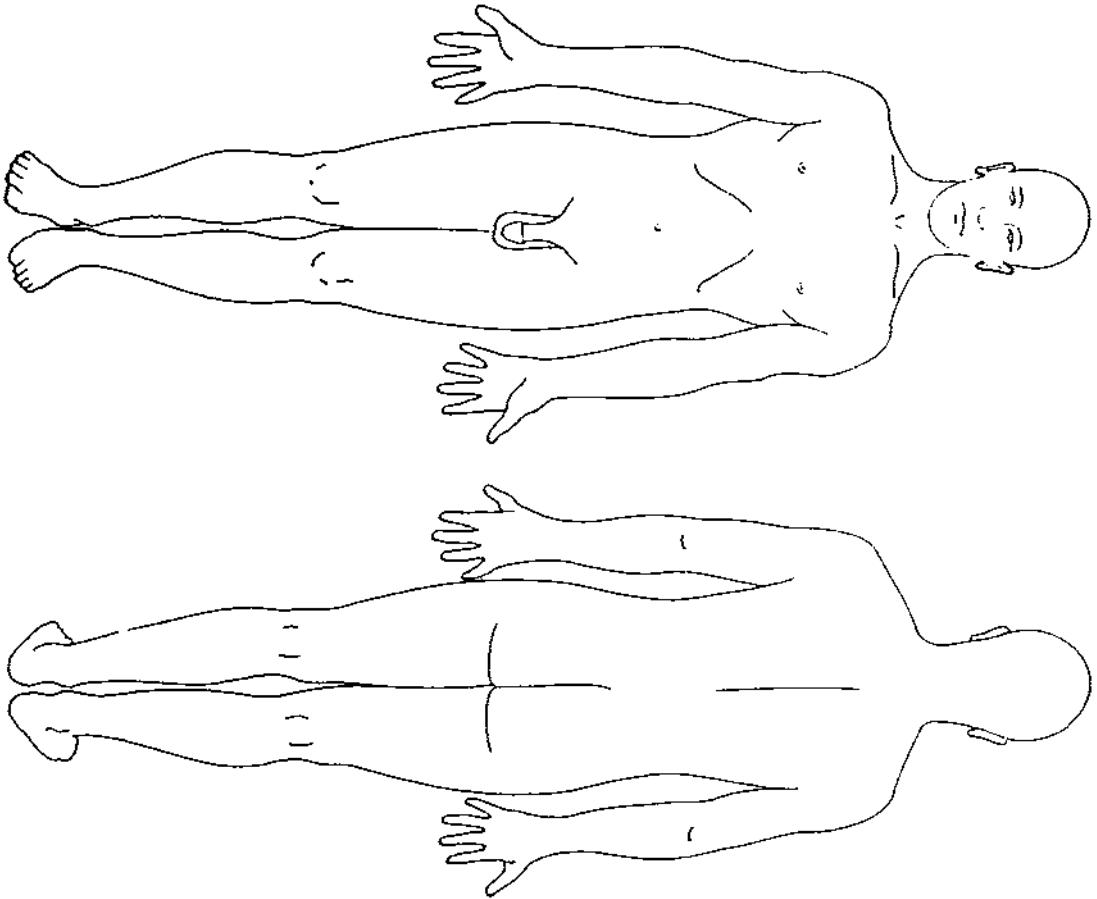


Name \_\_\_\_\_

Case No. \_\_\_\_\_

Date \_\_\_\_\_

FULL BODY, MALE—ANTERIOR AND POSTERIOR VIEWS (VENTRAL AND DORSAL)

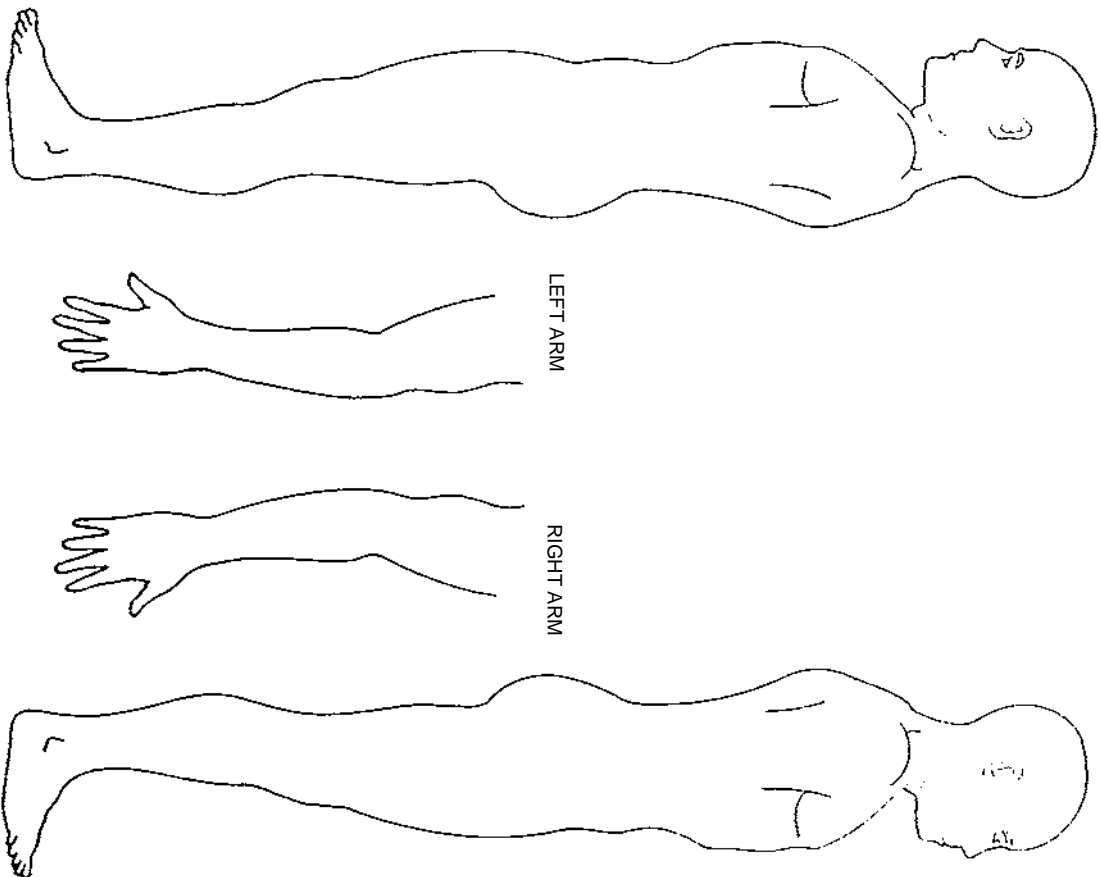


Name \_\_\_\_\_

Case No. \_\_\_\_\_

Date \_\_\_\_\_

FULL BODY, MALE—LATERAL VIEW

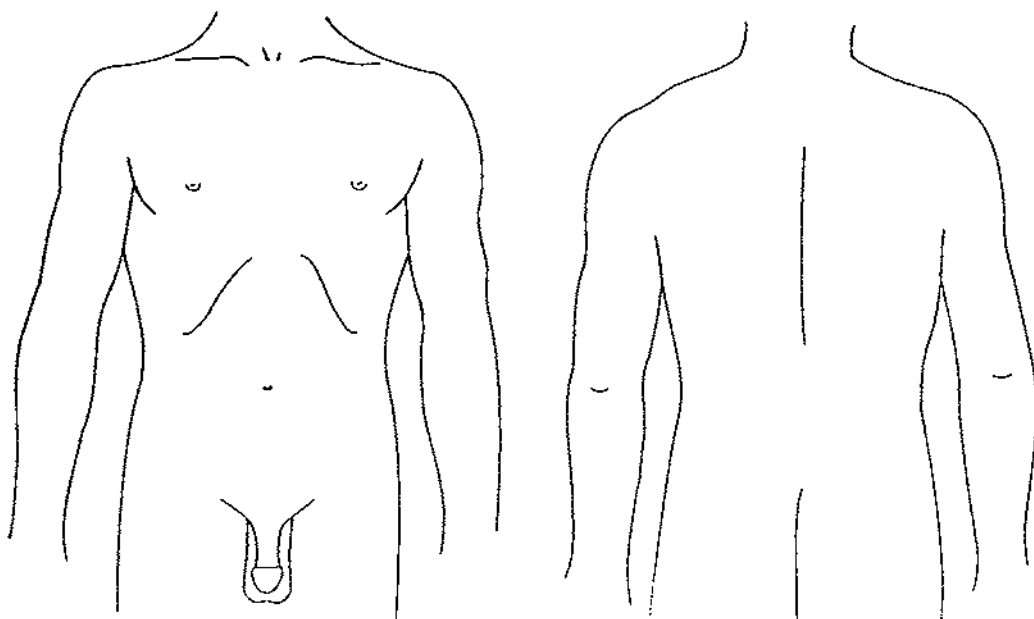


Name \_\_\_\_\_

Case No. \_\_\_\_\_

Date \_\_\_\_\_

THORACIC ABDOMINAL, MALE—ANTERIOR AND POSTERIOR VIEWS



Name \_\_\_\_\_

\_\_\_\_\_

Case No. \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

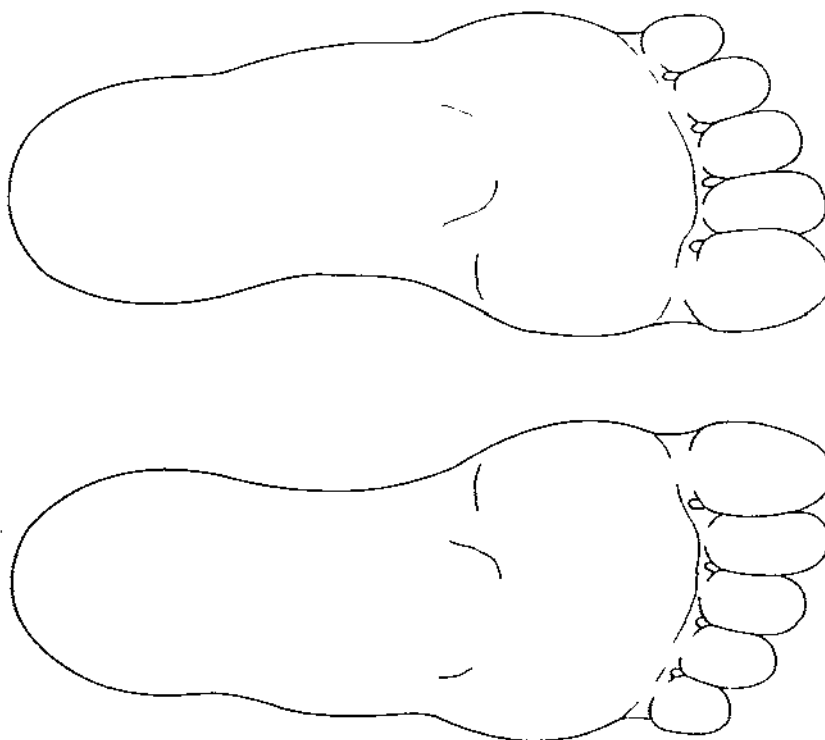
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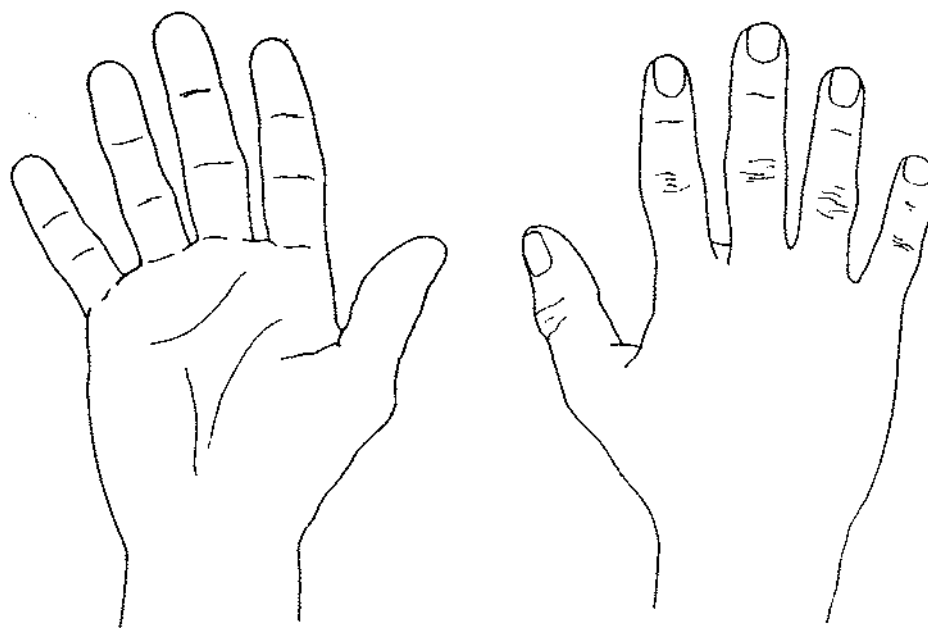
\_\_\_\_\_

Date \_\_\_\_\_

FEET—LEFT AND RIGHT PLANTAR SURFACES



RIGHT HAND—PALMAR AND DORSAL

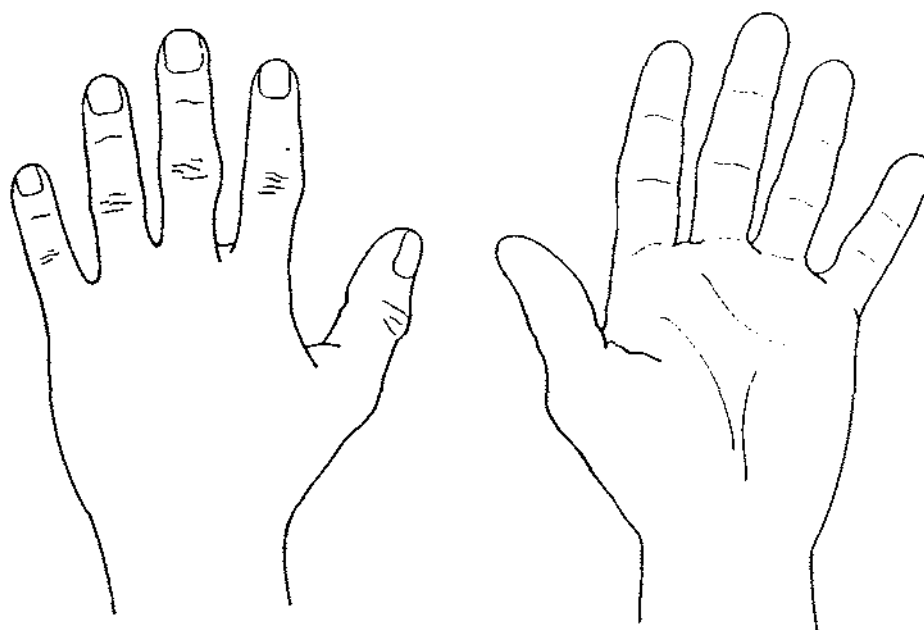


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Case No. \_\_\_\_\_

Date \_\_\_\_\_

LEFT HAND—PALMAR AND DORSAL

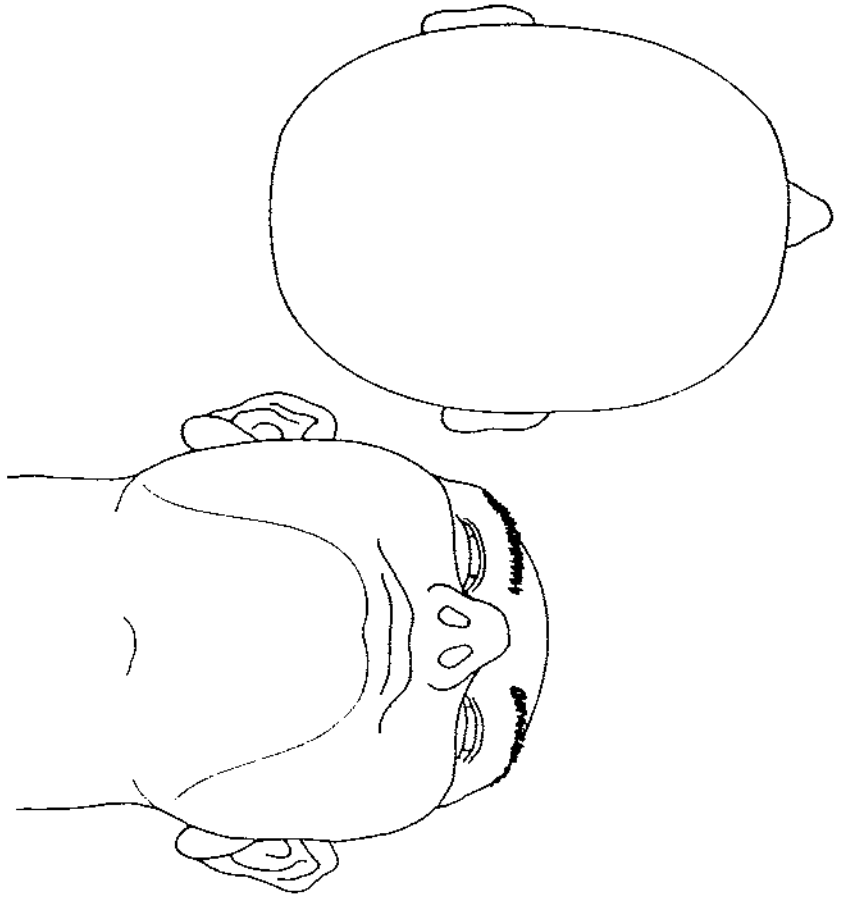


Name \_\_\_\_\_

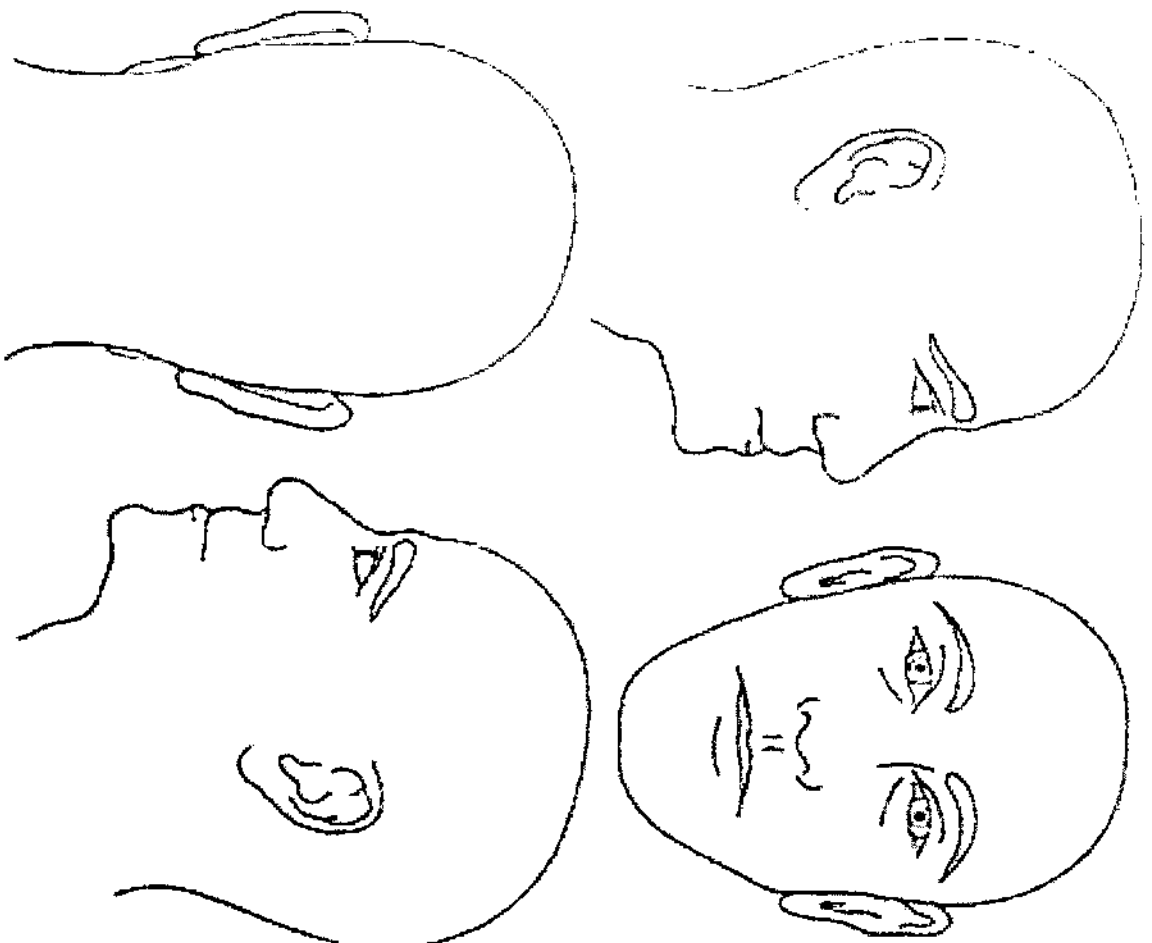
Case No. \_\_\_\_\_

Date \_\_\_\_\_

HEAD—SURFACE AND SKELETAL ANATOMY, SUPERIOR VIEW—INFERIOR VIEW OF NECK



HEAD—SURFACE AND SKELETAL ANATOMY, LATERAL VIEW



Name \_\_\_\_\_

Case No. \_\_\_\_\_

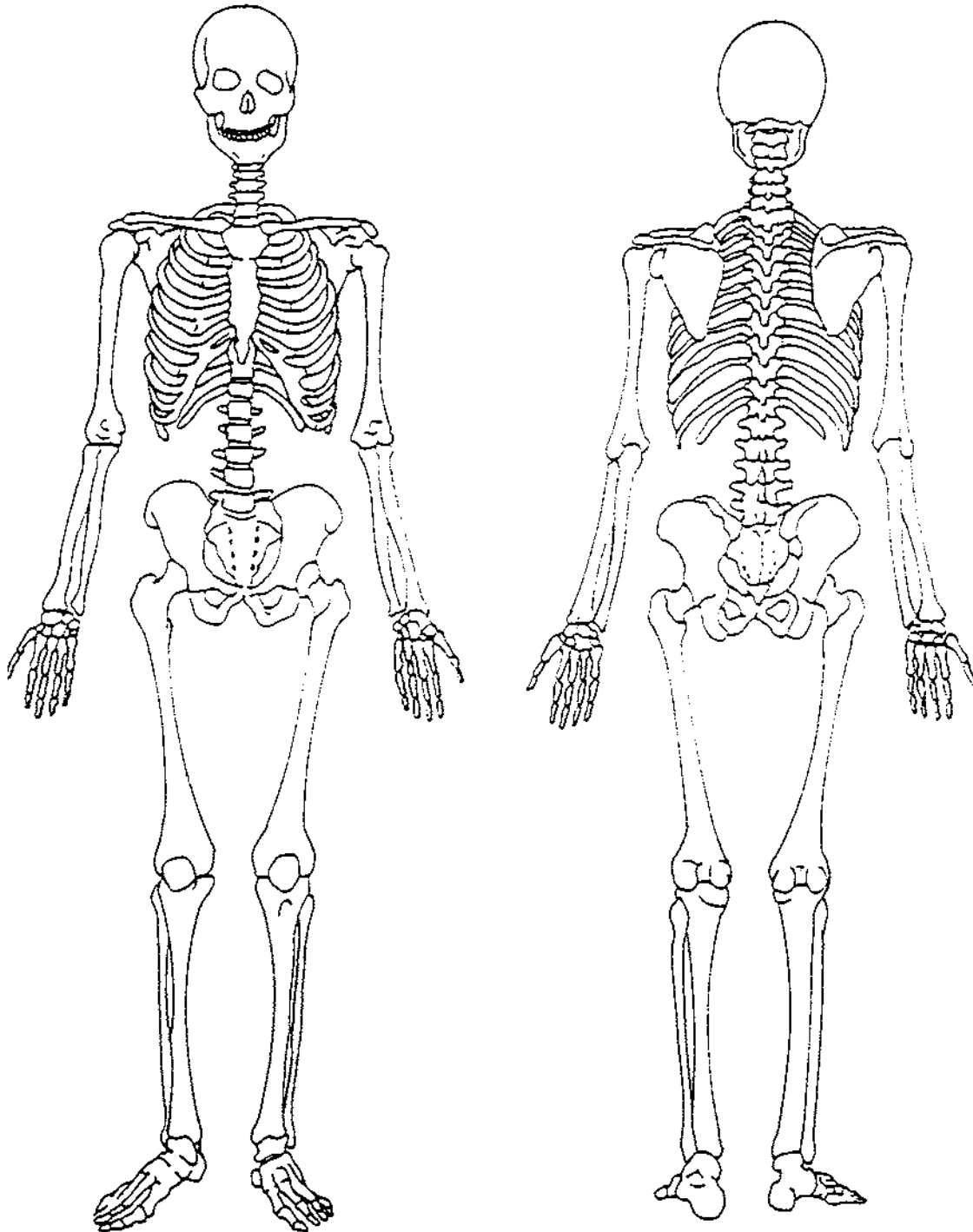
Date \_\_\_\_\_

Name \_\_\_\_\_

Case No. \_\_\_\_\_

Date \_\_\_\_\_

SKELETON—ANTERIOR AND POSTERIOR VIEWS



Name \_\_\_\_\_

Case No. \_\_\_\_\_

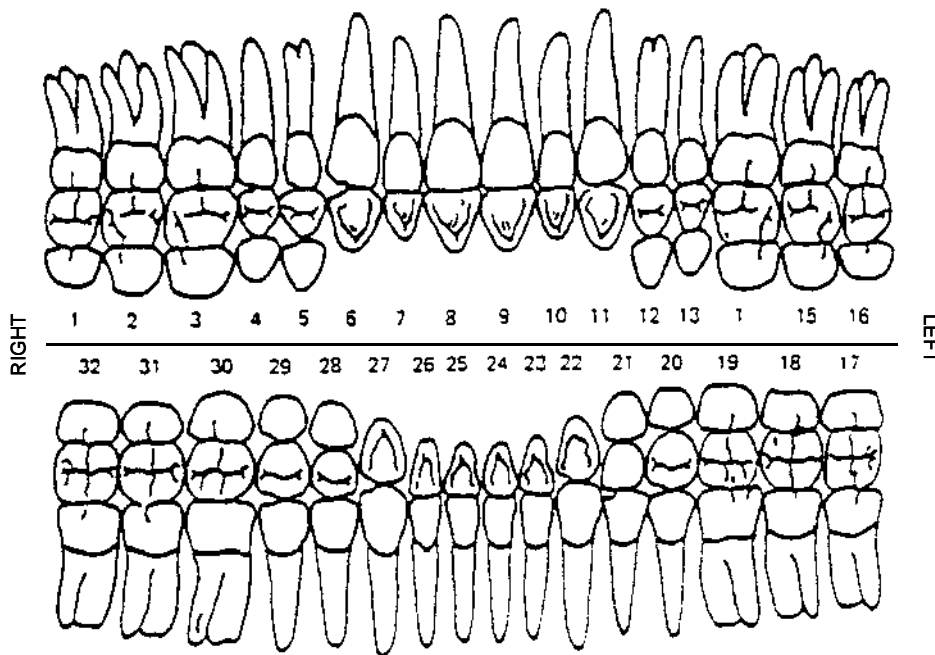
Date \_\_\_\_\_

MARK ALL EXISTING RESTORATIONS AND MISSING TEETH ON THIS CHART

Estimated Age \_\_\_\_\_

Sex \_\_\_\_\_

Race \_\_\_\_\_



Circle descriptive term

Prosthetic appliances present

Maxilla

Full denture

Partial denture

Fixed bridge

Mandible

Full denture

Partial denture

Fixed bridge

Describe completely all prosthetic appliances or fixed bridges \_\_\_\_\_

Stains on teeth

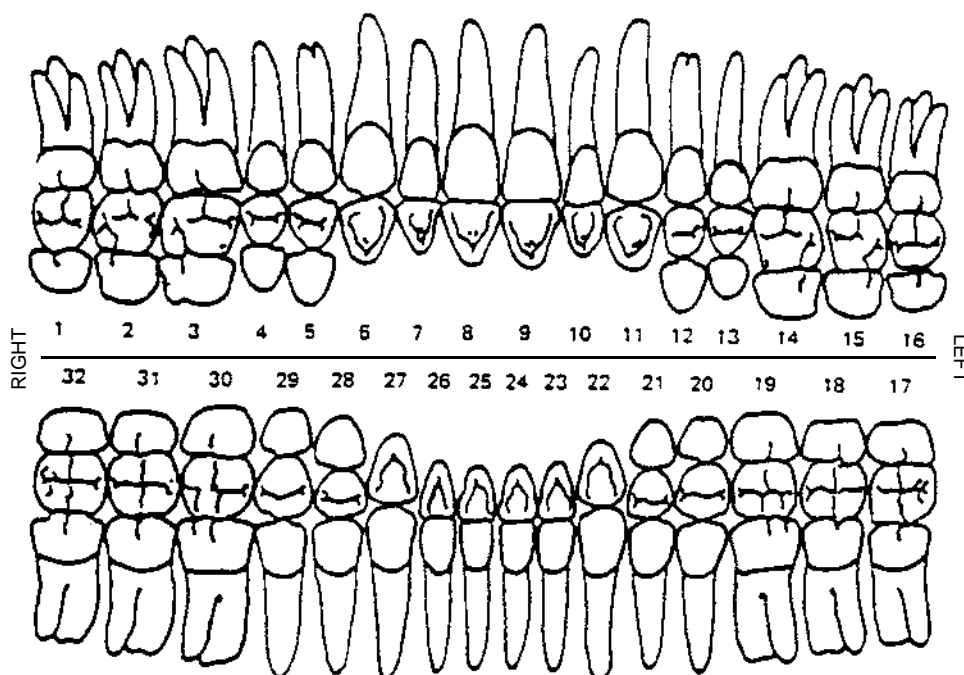
Slight

Moderate

Severe

MARK ALL CARIES ON THIS CHART

Outline all caries and "X" out all missing teeth



Circle descriptive term

Relationship

Normal

Undershot

Overbite

Periodontal Condition

Excellent

Average

Poor

Calculus

Slight

Moderate

Severe

## ANNEX IV

**Guidelines for the medical evaluation of torture and ill-treatment**

The following guidelines are based on the *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. These guidelines are not intended to be a fixed prescription, but should be applied taking into account the purpose of the evaluation and after an assessment of available resources. Evaluation of physical and psychological evidence of torture and ill-treatment may be conducted by one or more clinicians, depending on their qualifications.

**I. Case information**

Date of exam: ..... Exam requested by (name/position): .....

Case or report No.: ..... Duration of evaluation: ..... hours, ..... minutes

Subject's given name: ..... Birth date: ..... Birth place: .....

Subject's family name: ..... Gender: male/female: .....

Reason for exam: ..... Subject's ID No.: .....

Clinician's name: ..... Interpreter (yes/no), name: .....

Informed consent: yes/no If no informed consent, why?: .....

Subject accompanied by (name/position): .....

Persons present during exam (name/position): .....

Subject restrained during exam: yes/no; If "yes", how/why? .....

Medical report transferred to (name/position/ID No.): .....

Transfer date: ..... Transfer time: .....

Medical evaluation/investigation conducted without restriction (for subjects in custody): yes/no

Provide details of any restrictions: .....

**II. Clinician's qualifications** (for judicial testimony)

Medical education and clinical training

Psychological/psychiatric training

Experience in documenting evidence of torture and ill-treatment

Regional human rights expertise relevant to the investigation

Relevant publications, presentations and training courses

Curriculum vitae.



**III. Statement regarding veracity of testimony** (for judicial testimony)

For example: "I personally know the facts stated below, except those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

**IV. Background information**

General information (age, occupation, education, family composition, etc.)

Past medical history

Review of prior medical evaluations of torture and ill-treatment

Psychosocial history pre-arrest.

**V. Allegations of torture and ill-treatment**

1. Summary of detention and abuse
2. Circumstances of arrest and detention
3. Initial and subsequent places of detention (chronology, transportation and detention conditions)
4. Narrative account of ill-treatment or torture (in each place of detention)
5. Review of torture methods.

**VI. Physical symptoms and disabilities**

Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes.

1. Acute symptoms and disabilities
2. Chronic symptoms and disabilities.

**VII. Physical examination**

1. General appearance
2. Skin
3. Face and head
4. Eyes, ears, nose and throat
5. Oral cavity and teeth
6. Chest and abdomen (including vital signs)
7. Genito-urinary system
8. Musculoskeletal system
9. Central and peripheral nervous system.

**VIII. Psychological history/examination**

1. Methods of assessment
2. Current psychological complaints
3. Post-torture history
4. Pre-torture history
5. Past psychological/psychiatric history
6. Substance use and abuse history
7. Mental status examination
8. Assessment of social functioning
9. Psychological testing: (see chapter VI, sect. C.1, for indications and limitations)
10. Neuropsychological testing (see chapter VI, sect. C.4, for indications and limitations).

**IX. Photographs****X. Diagnostic test results** (see annex II for indications and limitations)**XI. Consultations****XII. Interpretation of findings**

1. Physical evidence
  - A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.
  - B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: The absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)
  - C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.
2. Psychological evidence
  - A. Correlate the degree of consistency between the psychological findings and the report of alleged torture.
  - B. Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.
  - C. Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time, i.e. what is the time frame in relation to the torture events and where in the course of recovery is the individual?
  - D. Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.
  - E. Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture or detention.

**XIII. Conclusions and recommendations**

1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and ill-treatment.
2. Reiterate the symptoms and disabilities from which the individual continues to suffer as a result of the alleged abuse.
3. Provide any recommendations for further evaluation and care for the individual.

**XIV. Statement of truthfulness** (for judicial testimony)

For example: "I declare under penalty of perjury, pursuant to the laws of ..... (country), that the foregoing is true and correct and that this affidavit was executed on ..... (date) at ..... (city), ..... (State or province)."

**XV. Statement of restrictions on the medical evaluation/investigation** (for subjects in custody)

For example: "The undersigned clinicians personally certify that they were allowed to work freely and independently and permitted to speak with and examine (the subject) in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities"; or "The undersigned clinician(s) had to carry out his/her/their evaluation with the following restrictions: ....."

**XVI. Clinician's signature, date, place****XVII. Relevant annexes**

A copy of the clinician's curriculum vitae, anatomical drawings for identification of torture and ill-treatment, photographs, consultations and diagnostic test results, among others.

*Further information can be obtained from:* The Office of the United Nations High Commissioner  
for Human Rights, Palais des Nations, 1211 Geneva 10, Switzerland

*Tel:* (+41-22) 917 91 59

*E-mail:* [infodesk@ohchr.org](mailto:infodesk@ohchr.org)

*Internet:* [www.ohchr.org](http://www.ohchr.org)

*UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT*

**PROCEEDINGS OF A MILITARY COMMISSION**

The military judge called the R.M.C. 803 session to order at Guantanamo Bay, Cuba, at 0923, 5 May 2012, pursuant to the following orders:  
Convening Order Number 12-02, dated 4 April 2012.

**[END OF PAGE]**

*UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT*

**UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT**

1 MJ [COL POHL]: The Military Commission is called to  
2 order.

3 TC [BG MARTINS]: Convening Order Number 12-02, dated  
4 4 April 2012, and referred capital for --

5 MJ [COL POHL]: Excuse me, gentlemen. Excuse me,  
6 General Martins. Can we put headphones on them? If we could  
7 please provide headphones for the accused.

8 I will note for the record while you are doing  
9 that, Mr. Bin'Attash is in a restraint chair. I will address  
10 issues in the proper order. I will get to that at the  
11 appropriate time. Again, I will get to it at the appropriate  
12 time, okay? Let the headphones go on and see if they work.  
13 Perhaps you need to say something to see if he can hear you.

14 Go ahead, General Martins. Okay. Just so  
15 everybody is clear, there is a process in this proceeding like  
16 any other proceeding. There is a time for motions. The time  
17 is at the time of arraignment. We will take all motions that  
18 you have in the order that you want to do them in, but I'm not  
19 taking them out of order, and I'm not taking them until we're  
20 done with the arraignment. For example, the accused have to  
21 select rights to counsel. I don't know if you have standing  
22 to say something on his behalf. I have to do qualifications,  
23 prosecutors' qualifications.

**UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT**

**UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT**

1           There is a process in place to follow the trial  
2 guide. Motions will be addressed at the time of arraignment.  
3 Clear?

4           DC [CDR RUIZ]: I understand that, Your Honor. I will  
5 cite to a Supreme Court case to address the issues at this  
6 time.

7           MJ [COL POHL]: What you can do is this: First, you can  
8 listen to me. Second of all, when you make your motion, when  
9 we get to that point, which will be today, if you want to go  
10 back and say I should have done it earlier, we can do it at  
11 that time. But I'm not taking motions out of order, clear?

12          DC [CDR RUIZ]: I'm not asking -- I would like to cite a  
13 Supreme Court case --

14          MJ [COL POHL]: You can cite the Supreme Court case when  
15 I give you the opportunity to be heard on the motion.

16          DC [CDR RUIZ]: Your Honor, we believe it is appropriate  
17 before the court is convened to address the issue. It is the  
18 heart of our motion.

19          MJ [COL POHL]: I will say it one more time, and that is  
20 the last time I'm going to say it. You will be able to make  
21 motions at the appropriate time. Now is not the appropriate  
22 time. Clear?

23          DC [CDR RUIZ]: I understand your position, Your Honor.

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1 We object.

2 MJ [COL POHL]: Okay. Your objection is on the record,  
3 please be seated.

4 Proceed, Trial Counsel.

5 TC [BG MARTINS]: Your Honor, this Military Commission is  
6 convened by Convening Order Number 12-02, dated 4 April 2012,  
7 and referred capital and for a joint trial as reflected on the  
8 charge sheet, copies of which have been furnished to the  
9 military judge. All counsel and each of the accused will be  
10 inserted at the appropriate place in the record.

11 MJ [COL POHL]: Please slow down.

12 TC [BG MARTINS]: There are no corrections to the  
13 Convening Order. Pursuant to the order signed by the Military  
14 Judge on 26 April, designated as Appellate Exhibit 007B, these  
15 proceedings are being transmitted to seven sites in the  
16 continental United States. The charges have been properly  
17 approved by the Convening Authority and referred to this  
18 Commission for trial.

19 As to Khalid Shaikh Mohammad, the prosecution  
20 caused a copy of the charges in English and Arabic, a language  
21 the accused understands, to be served on the accused on  
22 6 April 2012. A copy of the translated charge sheet is also  
23 attached to the record as Appellate Exhibit 19.

**UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT**

**UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT**

1           As to Walid Mohammad Salih Mubarak Bin'Attash, the  
2 prosecution caused a copy of the charges in English and  
3 Arabic, a language the accused understands, to be served on  
4 the accused on 6 April 2012. A copy of the translated charge  
5 sheet is also attached to the record as Appellate Exhibit 19.

6           As to Ramzi Binalshibh, the prosecution caused a  
7 copy of the charges in English and Arabic, a language the  
8 accused understands, to be served on the accused on 6 April  
9 2012. A copy of the translated charge sheet is also attached  
10 to the record as Appellate Exhibit 19.

11           As to Ali Abdul Aziz Ali, the prosecution caused a  
12 copy of the charges in English and Arabic, a language the  
13 accused understands, to be served on the accused on 6 April  
14 2012. A copy of the translated charge sheet is also attached  
15 to the record as Appellate Exhibit 19.

16           As to Mustafa Ahmed Adam al Hawsawi, the  
17 prosecution caused a copy of the charges in English and  
18 Arabic, a language the accused understands, to be served on  
19 the accused on 6 April 2012.

20           DC [CDR RUIZ]: Your Honor, on that issue may I be  
21 heard?

22           MJ [COL POHL]: Commander Ruiz.

23           DC [CDR RUIZ]: It is our position Mr. Hawsawi was not

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**UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT**

1 properly served. He did not receive the charges. I would  
2 like to state that for the record.

3 MJ [COL POHL]: Thank you. Again, if you have a motion  
4 that the charges weren't properly served, therefore an  
5 individual can't be arraigned, we will get to that.

6 Go ahead.

7 TC [BG MARTINS]: A copy of the translated charge sheet  
8 is also attached to the record as Appellate Exhibit 19.

9 The prosecution is ready to proceed in the case of  
10 United States vs. Khalid Shaikh Mohammad, also known as  
11 Mukhtar al Baluchi, Hafiz, Meer Akram, and Abdul Rahman  
12 Abdullah Al Ghamdi;

13 Walid Mohammad Salih Mubarak Bin'Attash, also  
14 known as Khallad, Salah Saeed Mohammed Bin Yousaf, Silver, and  
15 Tawfiq;

16 Ramzi Binalshibh, also known as Abu Ubaydah, Ahad  
17 Abdollahi Sabet, and Abu Ubaydah al Hadrami;

18 Ali Abdul Aziz Ali, also known as Ammar Al  
19 Baluchi, Isam Mansur, Isam Mansar, Isam Mansour spelled  
20 differently as noted on the charge sheet, Ali and Hani;

21 Mustafa Ahmed Adam al Hawsawi, also known as  
22 Zahir, Hashem Abdollahi, Mohammad Ahanad, and Abderahman  
23 Mustafa.

**UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT**

**UNOFFICIAL/UNAUTHENTICATED TRANSCRIPT**

1           Each of the accused and the following personnel  
2 detailed to this Commission are present:

3                   COLONEL JAMES POHL, MILITARY JUDGE;  
4                   BRIGADIER GENERAL MARK MARTINS, CHIEF  
5 PROSECUTOR;

6                   MR. EDWARD RYAN AND MR. ROBERT SWANN, TRIAL  
7 COUNSEL;

8                   MS. JOANNA BALTES, MR. JEFFREY GROHARING,  
9 AND MR. CLAYTON TRIVETT, DEPUTY TRIAL COUNSEL;

10                  MAJOR JOSHUA KIRK; LIEUTENANT KIERSTEN  
11 KORCZYNSKI; CAPTAIN MICHAEL LEBOWITZ; MAJOR ROBERT MCGOVERN;  
12 AND MS. NICOLE TATE, ASSISTANT TRIAL COUNSEL.

13                  As to Khalid Shaikh Mohammad:

14                  CAPTAIN JASON WRIGHT, DETAILED DEFENSE  
15 COUNSEL;

16                  MR. DAVID NEVIN, CIVILIAN LEARNED DEFENSE  
17 COUNSEL.

18                  Your Honor, I note that detailed but not present  
19 is Major Derek Poteet.

20                  MJ [COL POHL]: Thank you.

21                  TC [BG MARTINS]: As to Walid Mohammad Salih Mubarak  
22 Bin'Attash:

23                  CAPTAIN MICHAEL SCHWARTZ, DETAILED DEFENSE

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1 COUNSEL;

2 MS. CHERYL BORMANN, CIVILIAN LEARNED

3 DEFENSE COUNSEL.

4 Your Honor, I have a note that Major William  
5 Hennessy, Detailed Defense Counsel, is detailed but not  
6 present.

7 DC [CPT SCHWARTZ]: Hennessy is present.

8 MJ [COL POHL]: So I'm clear. Here currently, I will go  
9 through the counsel rights -- is Major Hennessy and Captain  
10 Schwartz are detailed counsel --

11 DC [CPT SCHWARTZ]: Both detailed.

12 MJ [COL POHL]: -- and Ms. Bormann, learned counsel for  
13 Mr. Walid Mohammad Salih Mubarak Bin'Attash.

14 TC [BG MARTINS]: As to Ramzi Binalshibh:

15 LIEUTENANT COMMANDER KEVIN BOGUCKI,  
16 DETAILED DEFENSE COUNSEL;

17 AND MR. JAMES HARRINGTON, CIVILIAN LEARNED  
18 DEFENSE COUNSEL.

19 As to Ali Abdul Aziz Ali:

20 LIEUTENANT COLONEL STERLING THOMAS,  
21 DETAILED DEFENSE COUNSEL;

22 AND MR. JAMES CONNELL, CIVILIAN LEARNED  
23 DEFENSE COUNSEL.

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1 As to Mustafa Ahmed Adam al Hawsawi:

2 COMMANDER WALTER RUIZ, DETAILED DEFENSE  
3 COUNSEL, ALSO SERVING AS LEARNED COUNSEL.

4 All other members are absent.

5 Court reporters have been detailed reporters for  
6 this Commission and have been previously sworn.

7 MJ [COL POHL]: As Chief Judge of the Military  
8 Commissions Trial Judiciary I detailed myself to this case.  
9 Previously sworn in accordance with R.M.C. 807. I'm certified  
10 qualified in accordance with Articles 26 Bravo and Charlie and  
11 42 Alpha, Uniform Code of Military Justice, as well as Rule  
12 For Military Commissions 503.

13 The court security officer has been previously  
14 sworn in accordance with Rule 10, Military Commissions Rules  
15 of court.

16 Each of the accused will now be advised of their  
17 rights to counsel and elect how they wish to be represented.  
18 Mr. Nevin, so I'm clear before I talk to Mr. Mohammad, you are  
19 learned counsel in this case; and Captain Wright is detailed  
20 counsel; Major Poteet is other detailed counsel, correct?

21 DC [MR. NEVIN]: That's correct, Your Honor.

22 MJ [COL POHL]: Mr. Connell?

23 DC [MR. CONNELL]: James Connell on behalf of Mr. Ali.

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1 I'll note in the script the court skipped over the clothing  
2 issue. I provided clothing to my client, which included a  
3 vest and headgear, and he was not permitted by Joint Task  
4 Force-Guantanamo to bring the vest and headgear into court.

5 MJ [COL POHL]: Mr. Connell, as I understand that part  
6 of the script deals with their prison garb, it was my  
7 understanding -- correct me if I'm wrong -- none of them are  
8 in prison garb, they are just not necessarily in the exact  
9 civilian clothing -- let me rephrase that -- exact nonprison  
10 garb that you want them in.

11 DC [MR. CONNELL]: That is accurate, sir.

12 MJ [COL POHL]: For purposes of this hearing, we will  
13 continue with that. If that is a real issue, we can address  
14 it going forward.

15 DC [MR. NEVIN]: I would say the same is true with  
16 Mr. Mohammad.

17 DC [MR. SCHWARTZ]: The same is true with us. They are  
18 not wearing what we provided to the SJA about 24 hours ago,  
19 which could have been scanned. It's a jacket with respect to  
20 our client. That was ----

21 MJ [COL POHL]: It strikes to me, the rule is they are  
22 entitled to wear appropriate nonprison garb attire, and if the  
23 JTF Commander makes some arbitrary and capricious decision on

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1 that, let me know about it and I will revisit it. That is all  
2 I can do at this point.

3 DC [CPT SCHWARTZ]: If we were told my client can wear a  
4 suit, a western American suit but not clothing of his choice,  
5 would that be arbitrary and capricious?

6 MJ [COL POHL]: I don't give advisory opinions. Just  
7 let me know what the issue is. If there is some reason why a  
8 certain item of clothing is denied, just because they don't  
9 like the style or something like that, that might strike me as  
10 arbitrary and capricious.

11 DC [MR. NEVIN]: Your Honor, David Nevin on behalf of  
12 Mr. Mohammad, I spoke to Colonel Thomas this morning about  
13 this. He told me the clothing we provided to Mr. Mohammad  
14 would not be allowed, and we asked him respectfully why not.  
15 He said, "It is not happening," or words to that effect.

16 MJ [COL POHL]: Okay.

17 DC [MR. NEVIN]: I said, "Is there an SOP? Is there some  
18 rule, some standard?" He wouldn't answer the question, told  
19 me simply the clothing we provided would not be allowed. The  
20 clothing we provided was simply a vest -- two vests, actually,  
21 Mr. Mohammad could choose from, as well as a turban.

22 MJ [COL POHL]: Who is it that told you this?

23 DC [MR. NEVIN]: Colonel Thomas, Colonel Donnie Thomas.

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1 I mean ----

2 MJ [COL POHL]: I got you. We will get -- let me go  
3 through this part of it. We will come back to this. It seems  
4 to me that is something we can address today at least.

5 DC [CPT SCHWARTZ]: Same issue with Mr. Hawsawi with  
6 respect ----

7 MJ [COL POHL]: Mr. Harrington, same thing?

8 DC [MR. HARRINGTON]: It is a cultural slash respect  
9 thing with the keffiyeh.

10 MJ [COL POHL]: We will get to it today. If I forget,  
11 remind me.

12 DC [MR. HARRINGTON]: One more issue is the length of  
13 the table, where I need to sit so -- you can see me here,  
14 where I need to sit so I can see and hear my client. The  
15 last-minute change to the script made this difficult.

16 You are aware we cannot bring in legal mail to  
17 speak over with the client prior to coming to court. I  
18 believe somebody had translated an Arabic copy of the original  
19 script, that script order was changed, and now my client is in  
20 the position that he is having a hard time following, I'm  
21 having a hard time communicating with him going back and  
22 forth. I'm wondering if Your Honor is aware of an Arabic  
23 version of the script that can be provided to the client?

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1 MJ [COL POHL]: As I understand it, the trial guide was  
2 amended up until yesterday. Also, it is just a trial guide.  
3 It is obviously easier for everybody to follow along, but as  
4 far as for your client, all the clients, I will talk to them;  
5 they have got to respond back to me, and they don't need the  
6 script or the trial guide in order to do that. With me on  
7 this?

8 What I'm saying is there is no current Arabic  
9 translation of the script that I'm operating from, and if he  
10 doesn't understand something, we can discuss it with him.  
11 Now, were you not provided translators?

12 DC [CPT SCHWARTZ]: I believe there are translators  
13 translating.

14 MJ [COL POHL]: I didn't ask that.

15 DC [CPT SCHWARTZ]: The team has a translator, yes. The  
16 difficulty ----

17 MJ [COL POHL]: I notice you have no translator at the  
18 table.

19 DC [CPT SCHWARTZ]: That would not help us at all; the  
20 translator will not be able to help me explain to the client  
21 any faster than I currently can why the script is out of  
22 order, why we are addressing issues he didn't anticipate. My  
23 question is ----

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1 MJ [COL POHL]: Okay, there are no new issues; it is  
2 simply some order changes. All the same, if you need time  
3 because he is confused to explain something to him, that's  
4 fine, you will get it.

5 DC [CPT SCHWARTZ]: Thank you.

6 DC [CDR RUIZ]: With respect to the question regarding  
7 the translator, Mr. Hawsawi's team has not had a translator  
8 for over a year. Since you asked the question of the Captain,  
9 I wanted to state for the record we have not had a dedicated  
10 translator on this case for over a year. That is why we don't  
11 have a translator here today.

12 MJ [COL POHL]: Okay. Again, Mr. Nevin, I will start  
13 with your client. It is my understanding ----

14 DC [CDR RUIZ]: And for the record, I don't speak  
15 Arabic.

16 MJ [COL POHL]: Thank you.

17 For the record, Major Poteet and Captain Wright  
18 are detailed counsel; you are learned counsel, correct?

19 DC [MR. NEVIN]: That is correct, Your Honor.

20 MJ [COL POHL]: Mr. Mohammad, can you hear me okay?

21 DC [MR. NEVIN]: Your Honor, if I could, I believe  
22 Mr. Mohammad will decline to address the court. I believe he  
23 's deeply concerned about the fairness of the proceeding and

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1 about the process that has brought us here in terms of our  
2 inability to communicate with him, limitations on what we can  
3 talk about with him. And he may or may not, I don't know, but  
4 if the court addresses him and he doesn't respond it will  
5 reflect a choice on his part to decline to communicate with  
6 the court.

7 MJ [COL POHL]: Mr. Nevin, just to make sure, are you  
8 convinced that the translation in the earphones are working  
9 for Mr. Mohammad?

10 DC [MR. NEVIN]: No, sir, I'm not. And I ----

11 MJ [COL POHL]: To me, we would have to make sure that  
12 occurs first, correct? I'm not saying necessarily "you," I'm  
13 saying there are all sorts of people that can verify whether  
14 the earphones are working or not.

15 DC [MR. NEVIN]: Your Honor, I don't know. I appeared  
16 in the Military Commissions in 2008, and the translations were  
17 notoriously inaccurate and late and behind ----

18 MJ [COL POHL]: That is a different issue.

19 DC [MR. NEVIN]: I understand.

20 MJ [COL POHL]: If he doesn't understand something,  
21 that's fine. I want to make sure he is hearing me and making  
22 a choice not to respond.

23 DC [MR. NEVIN]: I understand, Your Honor.

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1 MJ [COL POHL]: The only option I've got is for somebody  
2 to take the earphones off him and listen to it to make sure  
3 they are working okay, or you can propose another alternative.

4 DC [MR. NEVIN]: No, I don't have -- all I know is that  
5 I think Mr. Mohammad will decline to speak to the court or  
6 respond to the court.

7 MJ [COL POHL]: I got that. I want to make sure he is  
8 hearing the Commission. That is my question to you is that --  
9 is that I want to verify that he is hearing the translation.

10 DC [MR. NEVIN]: The record should reflect that  
11 Mr. Mohammad does not have earphones in his ears at this time;  
12 therefore, he is not listening to translation.

13 MJ [COL POHL]: The record should also reflect they were  
14 in his ears a minute ago and he chose to take them off.

15 DC [MR. NEVIN]: Yes, I think they were in, I don't  
16 know, about a minute ago, Your Honor.

17 MJ [COL POHL]: Do you wish to speak to your client, see  
18 whether or not he wishes to put the earphones in?

19 DC [MR. NEVIN]: No, sir, I don't, thank you. If the  
20 court is asking me to, I will.

21 MJ [COL POHL]: No, it is your choice.

22 DC [MR. NEVIN]: Yes, sir.

23 MJ [COL POHL]: But here is where we are going to go

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1 down on this, Mr. Nevin, is if he refuses to listen to the  
2 earphones, refuses to answer me -- I will ask him one more  
3 time in English; if he understands English and refuses to  
4 answer me, I will assume he is making a choice not to answer.  
5 Then we will go to the default.

6 DC [MR. NEVIN]: Do what, Your Honor?

7 MJ [COL POHL]: We will go to default elections.

8 DC [MR. NEVIN]: Could the court describe what that ----

9 MJ [COL POHL]: Yes. He gets detailed counsel, learned  
10 counsel, and he gets to enter a plea of not guilty with the  
11 defaults.

12 DC [MR. NEVIN]: The court would enter a plea and cause  
13 him to waive ----

14 MJ [COL POHL]: No, no, no, not today.

15 DC [MR. NEVIN]: That would be deferred?

16 MJ [COL POHL]: Not today. I'm simply saying one cannot  
17 choose not to participate and frustrate the normal course of  
18 business. That is all I'm saying. If Mr. Mohammad or any of  
19 the accused choose not to respond to my questions about  
20 elections of counsel, which is the first step, then we go to,  
21 as I said, the default counsel mode.

22 Eventually, if he refuses to enter a plea, when we  
23 get to that point, then the same thing happens; a plea of not

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1 guilty is entered on his behalf.

2 DC [MR. NEVIN]: Your Honor, I take it Mr. Mohammad has  
3 the right to remain silent and not respond to the court's  
4 questions.

5 MJ [COL POHL]: He can choose to do that as long as he  
6 understands the ramifications. But if he refuses to respond  
7 to my question and refuses to put the earphones on so he can  
8 hear a translation of my questions, then he is making a choice  
9 to be uninformed potentially from the Commission.

10 But, again, he can have that choice, but he does  
11 not have a choice that would frustrate this Commission going  
12 forward. Are you with me on this?

13 DC [MR. NEVIN]: No ----

14 MJ [COL POHL]: You have a furrowed brow. That's  
15 why ----

16 DC [MR. NEVIN]: I understand what Your Honor is saying.  
17 Mr. Mohammad may or may not have a particular intention with  
18 respect to pursuing the default, going to the default  
19 elections and so on. And I can't, I simply -- I don't know  
20 whether that is his intention. I understand what the court is  
21 saying.

22 MJ [COL POHL]: He has a choice. He can participate and  
23 make his elections, or he can choose not to participate and

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1 elections will be made for him. That's his choice.

2 DC [Mr. NEVIN]: Right. I understand that, Your Honor.

3 MJ [COL POHL]: Okay. Okay. Now, does he want to put the  
4 earphones back on?

5 DC [MR. NEVIN]: I doubt it.

6 MJ [COL POHL]: would you ask him?

7 DC [Mr. NEVIN]: Yes, sir.

8 DC [CAPT SCHWARTZ]: Your Honor, if I could just take the  
9 opportunity. We still have a headphone problem over here. I have  
10 replaced -- I don't want to interrupt if you want to keep going with  
11 Mr. Nevin.

12 MJ [COL POHL]: No, no, that's fine. Understand this, we have  
13 five accused here. They all have the same rights and same  
14 representational issues. When I'm talking to one lawyer and something  
15 comes up for another, feel free to interject. Go ahead.

16 DC [CAPT SCHWARTZ]: And the issue is just so my client can hear.  
17 Right now he is listening on headphones that I have provided. I have  
18 removed the court headphones. The reason for that is the torture that  
19 my client was subjected to by the men and women wearing the big boy  
20 pants down at the CIA it makes it impossible ----

21 MJ [COL POHL]: Captain?

22 [The security classification button was pushed by the Court Security  
23 officer at 0945, causing the live audio and video feed to terminate.]

24 DC [CAPT SCHWARTZ]: Yes, sir.

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MJ [COL POHL]: You know the rules.

DC [CAPT SCHWARTZ]: Your Honor, the rules with respect to what?

[The military judge briefly spoke with the Court Security Officer.  
There was a moment of brief silence.]

[The security classification button was pushed by the Court Security  
officer at 0946, resuming the live audio and video feed.]

DC [CAPT SCHWARTZ]: Your Honor, a brief record reflection.

MJ [COL POHL]: Okay. I'll note for the record that the  
screening device was instituted for one minute preventing the feed to  
go out.

Captain Schwartz?

DC [CAPT SCHWARTZ]: Your Honor?

MJ [COL POHL]: You know why it went off?

DC [CAPT SCHWARTZ]: I don't, because ----

MJ [COL POHL]: Well, then, let me explain something to you.  
There is certain material that is not to be disclosed in a public  
forum unless it has been properly cleared.

DC [CAPT SCHWARTZ]: Your Honor, I understand ----

MJ [COL PHOL]: And I don't want stopping and starting.

[END OF PAGE]

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1 You're kind of aware of where those lines are. I think you  
2 know right now where they are. If you want to litigate some  
3 issue that may raise classified issues, we may or may not  
4 close the court for it, but we can't just blurt them out.  
5 Clear?

6 DC [CPT SCHWARTZ]: Your Honor, that is clear.

7 MJ [COL POHL]: Right now, I don't need to know the  
8 reason why he needed different earphones. Do the ones you've  
9 given him work okay?

10 DC [CPT SCHWARTZ]: I need to check. For one, Your  
11 Honor, they don't, because I will note for the record two  
12 times now a guard has had to come over and fix the earphones.  
13 I understand that's because of the equipment that I provided.

14 But again, Your Honor, you said that I know where  
15 the line is. We will get to that later, I think, when we talk  
16 about our understanding of classified information and the  
17 script. I will tell you right now I don't know where the line  
18 is. I do know that my statement was not classified.

19 MJ [COL POHL]: Okay.

20 DC [CPT SCHWARTZ]: I know that it looks like the line  
21 right now is embarrassment to the government.

22 MJ [COL POHL]: Let's not debate that. I know your  
23 position might be that material is being prevented from going

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1 out to the world because it may be embarrassing, the  
2 government may say it is classified. I got it. I know how  
3 this works, okay?

4 But I don't want -- if we get near that line, I  
5 just want to do it in a normal course of action. It very well  
6 could be in an open session, but standing up in the middle of  
7 an arraignment and getting close to that line is not  
8 appropriate.

9 DC [CPT SCHWARTZ]: I understand, Your Honor.

10 MJ [COL POHL]: If you say your earphones don't work,  
11 the ones the government provided don't work, what is your  
12 alternative?

13 DC [CPT SCHWARTZ]: The alternative, Your Honor, would  
14 be to -- my client is sitting in restraints. I don't know the  
15 reason, exactly; we didn't have the opportunity to discuss it  
16 because the guards were not allowed to leave him and I to  
17 discuss anything privately. We honestly don't have that  
18 opportunity anywhere on this base as far as I can tell because  
19 we are listened to both here ----

20 MJ [COL POHL]: Stay on topic.

21 DC [CPT SCHWARTZ]: Okay.

22 MJ [COL POHL]: The topic is earphones.

23 DC [CPT SCHWARTZ]: My request would be to have my

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1 client unshackled so that he can himself place the earplug  
2 that I have provided back into his ear when it falls out.

3 MJ [COL POHL]: Now, I will assume without deciding that  
4 the reason your client is in that condition is because he was  
5 not voluntarily coming into this courtroom today.

6 DC [CPT SCHWARTZ]: That is my assumption, Your Honor.

7 MJ [COL POHL]: Are you telling me that if he is  
8 released from the shackles now, he will comport with the  
9 proper decorum in this Commission, just like the others are?

10 DC [CPT SCHWARTZ]: Are you asking me to vouch for that,  
11 Your Honor?

12 MJ [COL POHL]: No, I'm saying I'm not going to -- if he  
13 is in his current state because of actions that took place  
14 outside, assuming without deciding -- I wasn't there. I just  
15 see four unrestrained and one restrained, okay? But I'm not  
16 going to have him be unrestrained unless I have assurances  
17 from him that he will behave.

18 DC [CPT SCHWARTZ]: Your Honor, my guess is that he  
19 will. For the past 18 months, he has had several issues come  
20 up and ----

21 MJ [COL POHL]: Here is what I'm going to do, then. I'm  
22 going to ask him, and he is going to have to answer me, okay?

23 Mr. Bin'Attash, can you hear me?

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1 [No audible response.]

2 MJ [COL POHL]: Captain Schwartz, is he not hearing me  
3 or doesn't want to answer me?

4 DC [CPT SCHWARTZ]: Your Honor, I can't answer that. I  
5 don't know.

6 MJ [COL POHL]: Does he have earphones in?

7 DC [MAJ HENNESSY]: He appears to have earphones in.

8 MJ [COL POHL]: Okay. I'm assuming the earphones are  
9 working. He is refusing to answer me. Refusing to answer me  
10 means he will not agree -- nothing is changing.

11 Do you want to talk to your client?

12 DC [CPT SCHWARTZ]: May I have a moment, Your Honor?

13 MJ [COL POHL]: Sure.

14 DC [CPT SCHWARTZ]: Your Honor, my concern right now is  
15 my client is sitting in pain because of restraints. This is  
16 not a comfortable position for him to be in.

17 MJ [COL POHL]: Will he agree on the record to comport  
18 himself appropriately? That is all I need from him. If I get  
19 a simple yes, then I will consider the restraints being  
20 removed.

21 DC [CPT SCHWARTZ]: I don't know that he will.

22 MJ [COL POHL]: Then why should I remove the restraints?

23 DC [CPT SCHWARTZ]: Well, you didn't ask me to vouch for

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1 him.

2 MJ [COL POHL]: I don't want you to vouch for him. I  
3 just want him to simply tell me very simply that "if you took  
4 the restraints off, I will comport myself appropriately."

5 DC [CPT SCHWARTZ]: I can see, Your Honor, from your  
6 position that would seem reasonable. From my position the  
7 reason that he might not be cooperating with the court, there  
8 are many reasons, and they are serious reasons. To suggest  
9 that he is going to act out when that is not his behavior, I  
10 think ----

11 MJ [COL POHL]: Apparently it was his behavior outside,  
12 that is why he is in restraints and none of the others are.

13 DC [CPT SCHWARTZ]: The behavior outside are the  
14 conditions he has been dealing with, he has a prosthetic  
15 leg ----

16 MJ [COL POHL]: Captain Schwartz, I will not litigate  
17 this to death because it is a very simple issue. He has  
18 demonstrated, apparently -- again, I wasn't there -- but he  
19 wasn't going to comply with simple directions to move from the  
20 holding cells into the Commission itself. Therefore, he is  
21 put in a restraint chair. Okay.

22 Now, if he will tell me that he will now comply  
23 with reasonable decorum in this Commission, I will consider

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1 taking the restraints off. But he doesn't get the default  
2 like the other ones did because he has proven noncompliance.

3 DC [CPT SCHWARTZ]: Your Honor, he has proven he didn't  
4 want to come to court now. He is in court not by choice.

5 MJ [COL POHL]: All he has to do is tell me. It is not  
6 a hard question.

7 DC [CPT SCHWARTZ]: The position you are putting him in  
8 is one choice is pain; the other is to waive the right to  
9 remain silent?

10 MJ [COL POHL]: Waive his right to remain silent? What,  
11 the right to remain silent to say that he doesn't have to tell  
12 me he will obey the rules? You're telling me that is some  
13 type of waiver? Where is that right to remain silent in the  
14 statute?

15 DC [CPT SCHWARTZ]: Your Honor ----

16 MJ [COL POHL]: In the Constitution? Anywhere else?

17 DC [CPT SCHWARTZ]: Your Honor, I'm glad we are  
18 considering the constitutional question, but ----

19 MJ [COL POHL]: Do it without the editorial comments, it  
20 will go much faster.

21 DC [CPT SCHWARTZ]: Okay. Aside from the legal right, I  
22 believe my client has the ability to sit and participate or to  
23 sit and not participate, and that is up to him.

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1 MJ [COL POHL]: Absolutely.

2 DC [CPT SCHWARTZ]: The position you put him in, he has  
3 to participate.

4 MJ [COL POHL]: He has to answer one question to say  
5 that he will appropriately behave in this Commission.

6 DC [CPT SCHWARTZ]: So you would be forcing him ----

7 DC [CDR RUIZ]: I'm having trouble hearing Captain  
8 Schwartz all the way back ----

9 MJ [COL POHL]: Okay.

10 DC [CDR RUIZ]: Thank you.

11 MJ [COL POHL]: Captain Schwartz, we are revisiting old  
12 ground. It is your choice. It is your client's choice.

13 DC [CPT SCHWARTZ]: I just want to be clear for my  
14 client, myself and the record the position he is in right now  
15 is to break from what appears to be a strategy decision by him  
16 not to cooperate with the court for very many reasons, reasons  
17 that have extended over the past 18 months, reasons that  
18 JTF-GTMO has been aware of.

19 MJ [COL POHL]: Of course those reasons aren't part of  
20 the record because he is not cooperating. So all I get is  
21 your pronouncements.

22 Be that as it may, here are his choices. If he  
23 wants to be unrestrained, he has to tell me he will behave.

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1 If the answer is he refused to do this, he is staying like it  
2 is, it is his choice; not mine, his.

3 DC [CPT SCHWARTZ]: The pain issue aside, he can't hear  
4 without the guard having to constantly get up and fix the  
5 earplugs.

6 MJ [COL POHL]: I have given you options, Captain  
7 Schwartz. It is up to you what you want to do.

8 DC [CPT SCHWARTZ]: Thank you, Your Honor.

9 DC [CDR RUIZ]: Your Honor, if I may be heard, I think  
10 some issues also concern Mr. Hawsawi. Captain Schwartz  
11 alluded to some of the issues that have been ongoing the past  
12 year with each of the accused. This is the reason we were  
13 asking the court to hear the motion for defective referral  
14 before arraignment. Many of these issues we think would be  
15 aired out, perhaps the court would consider them and we would  
16 have the ability to discuss those facts.

17 That was one of the reasons the defense  
18 collectively sought to put this issue before the court and was  
19 one of the reasons I was trying to address you in the  
20 beginning and ask you to address the merits of the motion  
21 prior to engaging in the arraignment. We do think you have  
22 the discretion to do that. The Supreme Court certainly thinks  
23 you have the discretion to do that. I think what you are

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1 seeing is a reflection of the court's reluctance to get into  
2 this issue that we have put before the court. It is a legal  
3 issue. We think it has merit.

4 More importantly, the Supreme Court says you have  
5 the ability to do this. You have discretion to hear this  
6 issue before getting into this arraignment, before getting  
7 into these questions. And I neglected to put the case before  
8 the court before, which is United States vs. Thompson,  
9 94 S.Ct. 829. It says it is within the sound discretion of  
10 the court to address jurisdictional matters. In that  
11 particular case, it was the indictment itself. In this case,  
12 as we asked the court, our indication is that the court is not  
13 properly convened. Many of those reasons I think are also  
14 related to some of the issues that we are seeing here with our  
15 clients, some of their unwillingness to accept and comply with  
16 this court. Because it is my view and their view, the court  
17 is not willing to listen to the issues that we are properly  
18 putting before this court, even when the Supreme Court says  
19 you have the discretion to do this.

20 MJ [COL POHL]: Commander Ruiz, I will say this one more  
21 time. I will not say it again. There is an order we are  
22 going to follow. I told you what the order is going to be.  
23 I'm unfamiliar with any authority in an Article I court,

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1 whether commission or court-martial, that we get to motions  
2 until we have election of counsel. Point one.

3 Point two, you say it is in my discretion. In my  
4 discretion, we will do this at the end.

5 Point three, most importantly, so we are clear as  
6 we move forward, when I issue a ruling for either side, we are  
7 done. If you've got something new, okay, I will reconsider.  
8 But to stand up as you just did and tell me the exact same  
9 thing I told you before I didn't want to hear is not  
10 productive. Do you understand what I'm saying?

11 When I make a ruling, listen to it and we will  
12 move on. You will get your opportunity. You will not get it  
13 right this minute. More importantly is I told you that ten  
14 minutes ago, and apparently ten minutes later you decide to  
15 raise the issue again. We will get to it when I said we will  
16 get to it, I told you again. If you have a Supreme Court  
17 case, we will discuss it at the appropriate time; and now is  
18 not the appropriate time.

19 DC [CDR RUIZ]: The Supreme Court says you have the  
20 discretion to do it now. I want to make the court aware ----

21 MJ [COL POHL]: Listen to me for the last time. I told  
22 you I will do it when I get to it. I'm not doing it now.  
23 Clear?

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1 DC [CDR RUIZ]: I understand your position, Your Honor.

2 DC [CPT SCHWARTZ]: To close the loop on this, my client  
3 is sitting in pain. He assured me that he will not misbehave  
4 if he is released from his restraints, for the record, the  
5 guards have had to replace the headphones for the third time.

6 MJ [COL POHL]: Okay. Based on that representation,  
7 just so it is clear --

8 Mr. Harrington.

9 DC [MR. HARRINGTON]: Yes, sir.

10 MJ [COL POHL]: When the detainees stand up, the guards  
11 get excited. I'll note for the record, Mr. Binalshibh is now  
12 standing.

13 [Pause.]

14 MJ [COL POHL]: I will note for the record that  
15 Mr. Binalshibh appears to be standing and kneeling outside his  
16 chair without his headphones on.

17 Counsel, I can't see all the accused, but it  
18 appears a number of them do not have their headphones on. I'm  
19 assuming this is their choice. Mr. Nevin?

20 DC [MR. NEVIN]: Your Honor, I'm sorry?

21 MJ [COL POHL]: I'm just saying, is that -- if the  
22 detainees, the accused, choose not to use their headphones,  
23 they can't hear me.

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1 DC [MR. NEVIN]: And, Your Honor, the problem is with  
2 your word "choose." But now -- now you have me concerned  
3 because the warning light went off, and I gather it went off  
4 because the word "torture" was used.

5 I have understood for four years that allegations  
6 that the detainees were tortured ----

7 MJ [COL POHL]: Mr..Nevin.

8 DC [MR. NEVIN]: ---- was not classified, Your Honor.

9 MJ [COL POHL]: I can't speak -- I understand. What I'm  
10 simply saying is this ----

11 DC [MR. NEVIN]: It connects to the question the court  
12 asked me.

13 MJ [COL POHL]: You are going perhaps to the reason why  
14 they are not doing them. But my point is this, the why isn't  
15 really -- quite frankly, there is nothing I can do about the  
16 why at this time for that wrong. I'm not saying -- at the  
17 appropriate time, we may discuss that.

18 I'm simply saying to run the commissions, when you  
19 have non-English-speaking accused in any court, they are given  
20 the opportunity to listen in their native language.

21 Now, if you are saying they can't do that, then  
22 I'm going to ask you: What do you want done?

23 DC [MR. NEVIN]: But, Your Honor, you used the term he

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1 has chosen not to listen. The reason that he is not putting  
2 the earphones in his ears has to do with the torture that was  
3 imposed upon him.

4 MJ [COL POHL]: Okay. Let's ----

5 DC [MR. NEVIN]: So ----

6 MJ [COL POHL]: Move the why away for a second.

7 DC [MR. NEVIN]: But it's not a choice, a ----

8 MJ [COL POHL]: If it is not a choice, what is your  
9 remedy?

10 DC [MR. NEVIN]: Your Honor, I mean, I can speak to a  
11 remedy. But I need to understand whether the court is --  
12 where the line is with respect to what I can say and not say.

13 MJ [COL POHL]: Mr. Nevin, I don't want to get into that  
14 right now because that's not important. You say for this  
15 issue. I'm not saying it's not. Understand ----

16 DC [MR. NEVIN]: I know, I understand, Your Honor, it is  
17 important for this issue.

18 MJ [COL POHL]: Let me finish, please.

19 I know there is all sorts of things that both  
20 sides want to raise up at the appropriate time. I got that,  
21 okay? But I'm simply trying to get this process in place,  
22 okay.

23 You say that they don't want to use the earphones.

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1 Okay. Let's assume -- and we don't need to go into reasons,  
2 because I'm not saying give me an option on it. It may become  
3 significant in a minute, but not right now.

4 My question to you is: If we don't use earphones  
5 for them, what is your proposed way they can hear this  
6 proceeding in their native language?

7 DC [MR. NEVIN]: I don't have a suggestion about that,  
8 Your Honor. I can't tell the court -- I can tell you  
9 Mr. Mohammad graduated from a university in the United States  
10 and has some currency with the English language.

11 MJ [COL POHL]: That's not my question.

12 DC [MR. NEVIN]: Well, I mean, it is an option to the  
13 question of whether he has to listen to this in ----

14 MJ [COL POHL]: In his particular case, I got it. But  
15 it appears -- what I'm simply saying is -- again, I'm back to  
16 my process discussion earlier -- is that right now, in order  
17 for them to hear in their native language, each detainee, each  
18 accused, has been given the option of earphones with a  
19 translation. Okay.

20 You say they are not choosing not to use it,  
21 although I'll note for the record at times they were and at  
22 times they weren't. I'm not sure, that looks like a choice to  
23 me. It may not be to you, I got it.

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1 DC [MR. NEVIN]: If the court characterizes that as a  
2 choice and makes findings ----

3 MJ [COL POHL]: I'm not making any findings. I'm saying  
4 you say they can't use the earphones, and I'm saying okay, and  
5 you said, "but I'm not giving you a remedy." So, what do we  
6 do?

7 DC [MR. NEVIN]: Well, Your Honor, all I can tell you  
8 is, I can't force Mr. Mohammad to put earphones in his ears or  
9 listen in a particular way or pay attention or not. I can't  
10 force him to do that. And I can't make suggestions to the  
11 court about how it should proceed.

12 What I'm saying to the court is that what you are  
13 seeing here is a product of a number of things having to do  
14 with the way they were brought to court, with the way they  
15 were treated this morning, with the way their clothing has  
16 been dealt with, and with respect to a number of issues that  
17 arise out of their treatment in the camps over the last 12 to  
18 18 months.

19 And if the court wants to address this issue, if  
20 the court wants to engage this issue in any way other than a  
21 formalistic way to address this in a real, fair way, we have  
22 to address these issues.

23 MJ [COL POHL]: But -- okay.

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1 DC [MR. NEVIN]: They don't exist in abstract by  
2 themselves.

3 MJ [COL POHL]: Mr. Nevin, what is the first thing that  
4 you have to have -- what is the first thing I have to hear  
5 from each detainee? Who they want as their lawyer, okay?

6 DC [MR. NEVIN]: Your Honor, I entered ----

7 MJ [COL POHL]: What you're saying is I can't do that,  
8 so I have to assume that you're his lawyer.

9 DC [MR. NEVIN]: Yes, sir.

10 MJ [COL POHL]: If he refuses to answer, we will go from  
11 there.

12 General Martins, you are standing?

13 TC [BG MARTINS]: Your Honor, we would like to propose,  
14 at the court's discretion, an opportunity to bring in a  
15 consecutive translator that could be transmitted orally  
16 consecutively, not simultaneously, but at least allow an  
17 opportunity to get on the record that an Arabic translation is  
18 being provided audibly to the accused and can perhaps enable  
19 the ----

20 MJ [COL POHL]: Just to make sure I understand the  
21 proposed solution, instead of the earphones, we will use a --  
22 what we would normally do like in a military court-martial,  
23 where somebody will say something in English, then over the

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1 loudspeaker will come out the Arabic translation?

2 TC [BG MARTINS]: Yes, Your Honor.

3 MJ [COL POHL]: Okay. How long would it take to set  
4 that up?

5 TC [BG MARTINS]: Your Honor, we would need a brief  
6 recess to check with court personnel, a recess in place  
7 briefly to check with court personnel.

8 MJ [COL POHL]: Commission is recessed in place.

9 [The Military Commission recessed at 1012, May 5 2012.]

10 [The Military Commission was called to order at 1015, May 5  
11 2012.]

12 MJ [COL POHL]: The Commission is called to order. All  
13 parties again are present that were present when the  
14 Commission recessed. As I was saying earlier, the default in  
15 these Commissions for restraint on the detainees and the  
16 accused is no restraint, unless they show that restraints are  
17 required.

18 Captain Schwartz, you have indicated your client  
19 indicated that he would conduct himself appropriately if  
20 unrestrained?

21 DC [CPT SCHWARTZ]: He will, Your Honor.

22 MJ [COL POHL]: I will take him at his word at this time  
23 and direct the guard force to unrestrain him, please.

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1 DC [CPT SCHWARTZ]: Thank you, Your Honor.

2 Your Honor do you have a problem with the  
3 restraints being removed -- are you okay with the restraints  
4 being removed in the courtroom, as opposed to outside? That's  
5 a question from the guard.

6 MJ [COL POHL]: I have no problem with that, as long as  
7 the guard force can do it.

8 The record should reflect that Mr. Bin'Attash has  
9 now been unrestrained and is sitting in the same unrestrained  
10 posture all other detainees are.

11 Mr. Nevin, I think when we got on this point, the  
12 issue was whether or not he wanted to respond and whether he  
13 could hear me. And this can go for all the other ones so they  
14 understand: I intend to advise each accused of their rights  
15 of counsel. If they choose not to respond, then we will go to  
16 the default, as I discussed earlier.

17 DC [MR. NEVIN]: Your Honor, will the court allow me to  
18 explain to you why Mr. Mohammad is not responding? I  
19 think ----

20 MJ [COL POHL]: Let me ask you this: Does it make any  
21 difference? By that, what I mean is this: Let's say he has  
22 the best reason in the world. Let's say he has a legally  
23 recognizable reason. Let's say it is something that everybody

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1 would agree, "Oh, that is why he is not going to talk." Let's  
2 say that. What difference does it make?

3 DC [MR. NEVIN]: It makes all the difference in the  
4 world, Your Honor.

5 MJ [COL POHL]: No, it does not, Mr. Nevin. If he  
6 refuses to respond, I have to give him his lawyers. If he  
7 refuses to respond, the results are the same no matter what  
8 the reason is.

9 DC [MR. NEVIN]: Yes, Your Honor, but Mr. Mohammad would  
10 like for the court to know and I would like for the court to  
11 know ----

12 DC [CDR RUIZ]: Your Honor, I'm having trouble following  
13 because some of the translations are overlapping Mr. Nevin and  
14 the court.

15 MJ [COL POHL]: Got it.

16 DC [MR. NEVIN]: Mr. Mohammad would like the court to  
17 know, I would like the court to know, I will say for the  
18 record the world is watching this proceeding. Mr. Mohammad  
19 would like everyone to know ----

20 DC [CDR RUIZ]: I cannot hear what counsel is arguing  
21 over the translation.

22 MJ [COL POHL]: We have to do this in bite-size chunks.

23 DC [MR. NEVIN]: Your Honor, it is very, very hard to

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1 speak in bite-size chunks. And I will say we had similar  
2 translation problems in the last iteration of the Commissions,  
3 and I came away from that experience -- from that experience  
4 promising myself, if I were ever put in this position again, I  
5 would object to it because I cannot advocate for my client  
6 when I'm forced to speak like a robot.

7 Now, having said that ----

8 MJ [COL POHL]: Mr. Nevin, your objection is on the  
9 record. You objected to the earphones for simultaneous  
10 translation, you object to this technique, and I'm not that  
11 smart; you got an Option C?

12 DC [MR. NEVIN]: Your Honor, my remark about --

13 DC [CDR RUIZ]: I don't know what the technology is,  
14 Your Honor, but is there a way there can be a running  
15 transcript on the screen, no audio, no verbal -- I said  
16 before, I'm not counting ----

17 INT: The interpreters can only do one at a time.

18 MJ [COL POHL]: Mr. Ruiz.

19 DC [CDR RUIZ]: Ruiz.

20 MJ [COL POHL]: I don't know. Do you want a running  
21 Arabic translation on the screen?

22 DC [CDR RUIZ]: Yes, if there is a third option, if that  
23 were a solution, perhaps we can attempt to do that.

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1 INT: The interpreters cannot do two at a time. Can we  
2 have one speaker at a time, please?

3 MJ [COL POHL]: Got it.

4 Mr. Nevin?

5 DC [MR. NEVIN]: Your Honor, I understand the court's  
6 point. But on the other hand, these problems arose with the  
7 headphones and the simultaneous translation through headphones  
8 previously because the translation was unable to keep up and  
9 we were required to speak very slowly. And I simply raise the  
10 issue. I make the observation at this point.

11 But, Your Honor, my point is, it is critically  
12 important that the court and that everyone who has an interest  
13 in this case understands that there are valid reasons for  
14 Mr. Mohammad's refusal. May I simply articulate these  
15 matters, Your Honor?

16 MJ [COL POHL]: No, and I will explain why. Counsel are  
17 not witnesses, and whatever you tell me would make you either  
18 a witness or a purveyor of what your client told you.

19 I wish to make it clear, there is no problem with  
20 the defense putting on all relevant evidence on any issue at  
21 the appropriate time. If that includes how the accused were  
22 treated from point A until today, you will be given that  
23 opportunity. But right now is not that time for that issue,

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1 because I have to first see who the detainees want, who the  
2 accused want as their lawyers.

3           If you wish to tie in his rationale for not  
4 speaking to me now with some other issue, I will let you do  
5 that. What I'm simply saying is that right now it doesn't  
6 matter, because I have to go over rights to counsel. And,  
7 Mr. Nevin, you made your record, I understand your position.  
8 You might not agree with mine is not the issue.

9           The issue is I wanted to get the rights of counsel  
10 done. If treatment issues come up later on, or attacks, what  
11 I would say are relevant issues, I will give you every  
12 opportunity to do it. I fail to see how it is relevant at  
13 this time.

14          DC [MR. NEVIN]: And I think I can cut to the chase for  
15 this part by simply asking the court for permission to make a  
16 proffer of the reasons for Mr. Mohammad's refusal to engage  
17 the court.

18          MJ [COL POHL]: Mr. Nevin, I understand your position.  
19 I disagree with it. I don't think it is relevant at this  
20 time. Your request for proffer is denied.

21          DC [MS. BORMANN]: Judge, my name is Cheryl Bormann.  
22 I'm learned counsel for Mr. Bin'Attash. I respectfully  
23 disagree with the court. If the court says it doesn't matter

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1 what happened to Mr. Bin'Attash, may the court remember the  
2 world is watching ----

3 MJ [COL POHL]: Ms. Bormann, I did not say that. I  
4 simply said until they give me the rights to counsel, I can't  
5 do anything other than simply -- (inaudible.)

6 I know there are significant issues here. I know  
7 there is great interest here. But now is not the time to do  
8 it ----

9 DC [CPT SCHWARTZ]: But, Judge, it affects ----

10 DC [CDR RUIZ]: Again, we are getting overlap. I'm not  
11 following.

12 DC [MS. BORMANN]: It affects what you are going to do  
13 next. The whole premise that you need to advise them of their  
14 rights to counsel is then who they choose. You are asking  
15 them to make a focused and intelligent decision. What has  
16 happened to these men this morning and over the last eight  
17 years makes that particularly difficult. This morning, my  
18 client ----

19 MJ [COL POHL]: Ms. Bormann, please. How we got to this  
20 point that they do not want to answer my questions -- I will  
21 say it once more. I understand everybody disagrees, at least  
22 on this side. How we got here doesn't make any difference.  
23 If each accused refuses to answer my questions, for whatever

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1 reason, we are at the exact ----

2 DC [CDR RUIZ]: I cannot hear you, Your Honor.

3 MJ [COL POHL]: We are still at the exact point where I  
4 have to go over counsel rights with them.

5 DC [MS. BORMANN]: Judge, if you rectify, or at least  
6 attempt to rectify, some of the issues that have arisen this  
7 morning as a result of the treatment of my client by JTF-GTMO,  
8 you may be able to complete the task at hand. And  
9 Commander Ruiz and Mr. Nevin have attempted to make that  
10 argument to you.

11 I'm here because I think the court is making a  
12 mistake. What happened to these men this morning has affected  
13 their ability to focus on the proceedings at hand, and I am  
14 asking you to listen to these lawyers for these men when they  
15 say to you that these men have been mistreated.

16 MJ [COL POHL]: Ms. Bormann, I understand your position.  
17 I disagree with it. I will proceed as I said.

18 DC [MS. BORMANN]: Thank you.

19 DC [CDR RUIZ]: On election of counsel, I understand the  
20 court's position. This procedure is similar to what at times  
21 is used in federal courts. I know there is a great deal of  
22 discussion about this ----

23 MJ [COL POHL]: Commander Ruiz, come up to the podium.

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1 Go ahead.

2 DC [CDR RUIZ]: Just a suggestion, Your Honor. Perhaps  
3 one procedure the court wants to do, what we do in federal  
4 courts, is limited for the purpose of hearing the issue we  
5 raised.

6 I think if you were to ask at least some of the  
7 men if they were willing to elect counsel for purposes of  
8 hearing the defective referral motion and whether this court  
9 has the authority to proceed from that point on, perhaps it  
10 would solve your issue with respect to election of counsel, at  
11 least for the purpose of addressing this issue which we think  
12 is jurisdictional. I think it is important because it  
13 addresses the court's ability to proceed from here on out.

14 My suggestion is that if we do need to get in  
15 counsel rights, and I understand the desire, perhaps we can  
16 proceed with what we do in federal courts, which is enter  
17 appearances on this issue and rights for counsel on this  
18 issue.

19 If the court deems there is authority for this  
20 court to properly continue because it's properly referred,  
21 it's properly created, at that point, perhaps the court can  
22 address the detainees again and ask if they elect counsel for  
23 the remainder of the proceedings.

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1                   Again, it is solely within your discretion. The  
2 Supreme Court, I think, supports that. It may be a middle  
3 road and solution to this problem.

4           INT: Can the interpreters ask to be given the chance  
5 not to overlap?

6           DC [CDR RUIZ]: That is all I have.

7           MJ [COL POHL]: Commander Ruiz indicated that I have a  
8 desire or a need to go over counsel rights. I have a  
9 responsibility and a duty to go over counsel rights. If the  
10 accused wishes to be represented by counsel and later changes  
11 his mind and terminates that counsel's representation, that is  
12 his option.

13                   Similarly, if for some reason as I discuss counsel  
14 rights today with the accused and there is a reason later on  
15 that we need to revisit said advisement, I will do that.

16                   However, the rules are very clear that until I get  
17 a counsel election from the accused or a refusal to make said  
18 election, counsel have no standing to argue on behalf of the  
19 accused on any issue.

20                   Accordingly, I will proceed with the normal  
21 counsel advisement rights. If the accused refuses to respond,  
22 then counsel will be appointed in accordance with applicable  
23 rules as discussed earlier.

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1                   Mr. Mohammad, pursuant to the Manual for Military  
2 Commissions, you are represented by Major Poteet and Captain  
3 Wright, your Detailed Defense Counsel. Do you understand  
4 this?

5                   The accused refuses to answer.

6                   Detailed Defense Counsel are provided to you free  
7 of charge. Do you understand this?

8                   The accused refuses to answer.

9                   You also have the option to request an individual  
10 military counsel. You may ask the Chief Defense Counsel to  
11 provide any attorney from his office that you wish if that  
12 attorney is reasonably available. If your request for  
13 individual military counsel is approved, Major Poteet and  
14 Captain Wright will normally no longer be available to  
15 represent you.

16                  You may request that Chief Defense Counsel let  
17 your Detailed Defense Counsel stay on the case, but your  
18 request would not have to be granted.

19                  Do you understand this?

20                  Accused refuses to answer.

21                  Do you wish to ask for individual military  
22 counsel?

23                  Accused refuses to answer.

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1           In addition to Detailed Defense Counsel, you have  
2 the right to at least one additional counsel who is learned in  
3 applicable law related to capital cases, and who, if  
4 necessary, may be a civilian compensated in accordance with  
5 regulations prescribed by the Secretary of Defense.

6           In your case, your learned counsel is Mr. David  
7 Nevin, a civilian lawyer. Mr. Nevin is specially trained and  
8 experienced in cases in which a death sentence may be  
9 adjudged. Do you understand this?

10           Accused refuses to answer.

11           You may also have a civilian lawyer of your choice  
12 represent you at no expense to the government. To be  
13 qualified, he or she must be a U.S. citizen, admitted to the  
14 practice of law in a state, district, territory or possession  
15 of the United States or a federal court, may not have been the  
16 subject of disqualifying action by a bar or other competent  
17 authority, be eligible for a Secret clearance or higher as  
18 required, and agree in writing to comply with the orders,  
19 rules, and regulations of these Military Commissions.

20           If a civilian lawyer represents you, your Detailed  
21 Defense Counsel will continue to represent you as well unless  
22 you specifically waive the right to be represented by Detailed  
23 Defense Counsel. Do you understand what I have just told you?

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1                   The accused refuses to answer.

2                   Do you have any questions about your rights to  
3 counsel before this Commission?

4                   Accused refuses to answer.

5                   Do you desire to be represented by Major Poteet,  
6 Captain Wright and Mr. Nevin?

7                   Accused refuses to answer.

8                   Do you want any other qualified counsel?

9                   The accused refuses to answer.

10                  Mr. Mohammad, in the event that counsel might  
11 disagree on a matter concerning your representation, I need  
12 you to designate the lead counsel who will speak for you and  
13 the defense team. Whom do you designate as lead counsel?

14                  The accused refused to answer.

15                  Given the accused's failure to respond and make an  
16 overt election, he will now be represented by his detailed  
17 counsel and Mr. Nevin. Later on we will go over counsel's  
18 qualifications.

19                  Captain Schwartz, just so I'm sure who is on the  
20 defense team here, it's Major Hennessy, yourself and  
21 Ms. Bormann, is that correct?

22                  DC [CPT SCHWARTZ]: Correct.

23                  MJ [COL POHL]: Ms. Bormann is learned counsel?

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1 DC [CPT SCHWARTZ]: Yes.

2 MJ [COL POHL]: Mr. Bin'Attash, pursuant to the Manual  
3 for Military Commissions, you are represented by  
4 Major Hennessy, your Detailed Defense Counsel, and Captain  
5 Schwartz, your assistant Detailed Defense Counsel.

6 Do you understand this?

7 DC [MS. BORMANN]: Captain Schwartz is actually  
8 additional Detailed Defense Counsel.

9 MJ [COL POHL]: Okay. Again, do you understand this,  
10 Mr. Bin'Attash?

11 Accused refuses to answer.

12 Detailed Defense Counsel are provided to you free  
13 of charge. Do you understand this?

14 The accused refuses to answer.

15 You also have the option to request an individual  
16 military counsel. You may ask the Chief Defense Counsel  
17 provide any attorney from his office that you wish if that  
18 attorney is reasonably available. If your request for an  
19 individual military counsel is approved, Major Hennessy and  
20 Captain Schwartz will normally no longer be available to  
21 represent you.

22 You may request the Chief Defense Counsel to let  
23 your Detailed Defense Counsel stay on the case, but your

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1 request would not have to be granted.

2 Do you understand this?

3 Just to be clear on the record -- I'm not sure  
4 this was put on the record before -- in lieu of the earphones,  
5 consecutive translation is being provided over a loudspeaker  
6 into the courtroom.

7 Mr. Bin'Attash, do you wish to ask for individual  
8 military counsel?

9 Captain Schwartz?

10 DC [CPT SCHWARTZ]: Yes, Your Honor.

11 MJ [COL POHL]: Are you standing?

12 DC [CPT SCHWARTZ]: Yes, Your Honor.

13 MJ [COL POHL]: You want to say something?

14 DC [CPT SCHWARTZ]: I do, Your Honor. Currently, Your  
15 Honor, the office of Chief Defense Counsel is not staffed,  
16 actually has never been staffed with a general officer or a  
17 flag officer.

18 MJ [COL POHL]: Captain Schwartz, does this have  
19 anything to do with his rights to counsel?

20 DC [CPT SCHWARTZ]: Absolutely, Your Honor.

21 MJ [COL POHL]: Okay. If you have a motion about  
22 resourcing, we will get to it.

23 DC [CDR RUIZ]: May I ask for -- I did not hear Captain

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1 Schwartz' communication to the court.

2 MJ [COL POHL]: Okay. Let's make this clear again.

3 Everybody is going to have ample opportunity to litigate  
4 whatever issues they want. If there is an issue of resources  
5 or staffing, everybody will get an opportunity to litigate it.  
6 But now is not the time.

7 I'm going through rights to counsel. When I'm  
8 done with it, if you have an issue you wish to raise, do it at  
9 that time. I'm not going to piecemeal with each counsel  
10 raising an issue that has got nothing to do with rights to  
11 counsel. And if I'm wrong, and it does have something to do  
12 with rights to counsel, we will revisit it. Clear, Captain  
13 Schwartz?

14 DC [CPT SCHWARTZ]: Your Honor, it is clear; I just  
15 don't see it as a litigating resources issue. I think it has  
16 to do with rights to counsel. I thought we could clear up now  
17 the fact that he can't request somebody of equal rank.

18 MJ [COL POHL]: That is absolutely correct. My point to  
19 you is, if you have an issue about his counsel rights and the  
20 limitation on them, that's a motion.

21 DC [CPT SCHWARTZ]: Understood, Your Honor. We will  
22 raise that motion. I just wanted to be clear he does not have  
23 that right today.

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1 MJ [COL POHL]: Okay. Got it. I got it. He has the  
2 rights that I'm telling him about. If you think he is  
3 entitled to or has a statutory or regulatory or any other  
4 basis for additional rights, we will talk about that at the  
5 appropriate time.

6 DC [CPT SCHWARTZ]: Thank you, Your Honor. I was not  
7 trying to educate you. I was trying to educate myself and my  
8 client.

9 MJ [COL POHL]: Mr. Bin'Attash, do you wish to ask for  
10 individual military counsel?

11 The accused refuses to answer.

12 In addition to Detailed Defense Counsel, you have  
13 the right to at least one additional counsel who is learned in  
14 applicable law relating to capital cases, and who, if  
15 necessary, may be a civilian and compensated in accordance  
16 with regulations prescribed by the Secretary of Defense. In  
17 your case your learned counsel is Ms. Cheryl Bormann, a  
18 civilian lawyer. Ms. Bormann is specially trained and has  
19 experience in cases in which a death sentence may be adjudged.

20 Do you understand this?

21 Accused refuses to answer.

22 You may also have a civilian lawyer of your choice  
23 to represent you at no expense to the government. To be

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1 qualified he or she must be a U.S. citizen, admitted to the  
2 practice of law in a state, district, territory or possession  
3 of the U.S., or a federal court, may not have been subject of  
4 a disqualifying action by a bar or other competent authority,  
5 be eligible for a Secret clearance or higher as required, and  
6 agree in writing to comply with the orders, rules and  
7 regulations of these Military Commissions.

8           If a civilian lawyer represents you, your Detailed  
9 Defense Counsel will continue to represent you as well unless  
10 you specifically waive the right to be represented by Detailed  
11 Defense Counsel.

12           Do you understand what I have just told you?

13           The accused refuses to answer.

14           Do you have any questions about your right to  
15 counsel before this Military Commission?

16           The accused refuses to answer.

17           Do you desire to be represented by Major Hennessy,  
18 Captain Schwartz and Ms. Bormann?

19           The accused refuses to answer.

20           Do you want any other qualified counsel?

21           The accused refuses to answer.

22           Mr. Bin'Attash, in the event your counsel might  
23 disagree on a matter concerning your representation, I need

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1 you to designate the lead counsel who will speak for you and  
2 the defense team.

3 Whom do you designate as lead counsel?

4 The accused refuses to answer.

5 Given the accused's refusal to make an election to  
6 counsel, he will have his detailed counsel, Major Hennessy and  
7 Captain Schwartz, as well as his learned counsel, as his  
8 counsel in this Commission until such time as he makes other  
9 wishes known.

10 Mr. Harrington, Mr. Binalshibh is represented by  
11 yourself, Lieutenant Commander Bogucki ----

12 DC [MR. HARRINGTON]: My client would prefer to have his  
13 name pronounced Binalshibh [phonetic "bin al SHAIB-ah"].

14 MJ [COL POHL]: Okay. So Mr. Binalshibh would want to  
15 be represented by -- excuse me. Currently you are the learned  
16 counsel, correct? Lieutenant Commander Bogucki is the  
17 detailed counsel?

18 DC [MR. HARRINGTON]: Judge, just before you begin this  
19 issue, my client has the same issues as have been raised  
20 before. I understand your rulings. However, my client does  
21 not believe he is in a position to intelligently answer your  
22 questions with respect to counsel until the issues of  
23 confinement and other matters that have been raised before are

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1 addressed.

2           And as you know, under the current rules, we are  
3 not allowed to repeat anything that our client says to us  
4 because it is classified, which to the extent we could do that  
5 in this particular proceeding, it appears we are barred from  
6 doing so.

7           MJ [COL POHL]: At this point in time, correct.

8           DC [MR. HARRINGTON]: Secondly, Judge, with respect to  
9 Lieutenant Commander Bogucki, he has recently been detailed.  
10 Mr. Binalshibh has not had detailed counsel for a significant  
11 period of time and he has not had an opportunity to consult  
12 with Mr. Bogucki and determine whether he wants him as  
13 detailed counsel.

14          MJ [COL POHL]: Mr. Harrington, if later on -- he  
15 chooses today not to have him, if he chooses not to say  
16 anything today and later on wants to terminate his  
17 relationship, he has that option.

18          DC [MR. HARRINGTON]: I reiterate, Judge, he would not  
19 want to proceed without addressing the issues of confinement  
20 and other issues that have been addressed before.

21          MJ [COL POHL]: Thank you. Mr. Binalshibh, pursuant to  
22 the Manual for Military Commissions, you are represented by  
23 Lieutenant Commander Bogucki, your Detailed Defense Counsel.

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1 Do you understand this?

2 The accused refuses to answer.

3 Detailed Defense Counsel are provided to you free  
4 of charge.

5 Do you understand this?

6 The accused refuses to answer.

7 You also have the option to request an individual  
8 military counsel. You may ask the Chief Defense Counsel to  
9 provide any attorney from his office that you wish if that  
10 attorney is reasonably available.

11 If your request for an individual military counsel  
12 is approved, Lieutenant Commander Bogucki -- I apologize now,  
13 I'm sure I'm mispronouncing that -- will normally no longer be  
14 available to represent you. You may request the Chief Defense  
15 Counsel to let your Detailed Defense Counsel stay on the case,  
16 but your request would not have to be granted.

17 Do you understand this?

18 The accused refuses to answer.

19 Do you wish to ask for individual military  
20 counsel?

21 The accused refuses to answer.

22 In addition to Detailed Defense Counsel, you have  
23 the right to one additional counsel learned in applicable law

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1 applicable in capital cases, and who, if necessary, may be a  
2 civilian compensated in accordance with regulations prescribed  
3 by the Secretary of Defense.

4 In your case, your learned counsel is Mr. Jim  
5 Harrington, a civilian lawyer. Mr. Harrington is specially  
6 trained and has experience in cases in which a death sentence  
7 may be adjudged.

8 Do you understand this?

9 You may also have a civilian lawyer of your choice  
10 represent you at no expense to the government. To be  
11 qualified, he or she must be a U.S. citizen admitted to the  
12 practice of law in a state, district, territory or possession  
13 of the United States or a federal court, may not have been the  
14 subject of a disqualifying action by a bar or other competent  
15 authority, be eligible for a Secret clearance or higher as  
16 required, and agree in writing to comply with the orders,  
17 rules, and regulations of these Military Commissions.

18 If a civilian lawyer represents you, your Detailed  
19 Defense Counsel will continue to represent you as well, unless  
20 you specifically waive the right to be represented by Detailed  
21 Defense Counsel.

22 Do you understand what I have just told you?

23 The accused refuses to answer.

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1 Do you have any questions about your rights to  
2 counsel before this Military Commission?

3 The accused refuses to answer.

4 Do you desire to be represented by Lieutenant  
5 Colonel Bogucki and Mr. Harrington?

6 Accused refuses to answer.

7 Do you want any other qualified counsel?

8 In the event counsel might disagree on a matter  
9 concerning your representation, you need to designate the lead  
10 counsel to speak for you and the defense team.

11 Whom do you designate as lead counsel?

12 The accused refuses to answer.

13 In light of the accused's refusal to make counsel  
14 election, he will have detailed counsel, Lieutenant Commander  
15 Bogucki, and Mr. Harrington at this point in time.

16 Mr. Connell, are you the learned counsel for  
17 Mr. Ali? And his detailed counsel is Lieutenant Colonel  
18 Sterling Thomas?

19 DC [MR. CONNELL]: Correct, sir.

20 MJ [COL POHL]: Mr. Ali, pursuant to the Manual for  
21 Military Commissions, you are represented by Lieutenant  
22 Colonel Thomas, your Detailed Defense Counsel.

23 Do you understand this?

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1           The accused refuses to answer.

2           Detailed Defense Counsel are provided to you free  
3 of charge.

4           Do you understand this?

5           The accused refuses to answer.

6           You also have the option to request an individual  
7 military counsel. You may ask the Chief Defense Counsel to  
8 provide any attorney from his office that you wish if that  
9 attorney is reasonably available. If your request for an  
10 individual military counsel is approved, Lieutenant Colonel  
11 Thomas will normally no longer be available to represent you.  
12 You may request the Chief Defense Counsel to let your Detailed  
13 Defense Counsel stay on the case, but your request will not  
14 have to be granted.

15           Do you understand this?

16           The accused refuses to answer.

17           Do you wish to ask for individual military  
18 counsel?

19           The accused refuses to answer.

20           In addition to Detailed Defense Counsel, you have  
21 the right to at least one additional counsel who is learned in  
22 applicable law related to capital cases, and who, if  
23 necessary, may be a civilian and compensated in accordance

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1 with regulations prescribed by the Secretary of Defense. In  
2 your case your learned counsel is Mr. James Connell --  
3 Connell, a civilian lawyer.

4 DC [MR. CONNELL]: You had it right the first time,  
5 Connell [phonetic "Con-NELL"].

6 MJ [COL POHL]: Connell [phonetic "Con-NELL"], thank  
7 you.

8 Mr. Connell is specially trained and has  
9 experience in cases in which a death sentence may be adjudged.

10 Do you understand this?

11 The accused refuses to answer.

12 You may also have a civilian lawyer of your choice  
13 represent you at no expense to the government. To be  
14 qualified, he or she must be a U.S. citizen, admitted to the  
15 practice of law in a state, district, territory or possession  
16 of the U.S., or a federal court, may not have been the subject  
17 of a disqualifying action by a bar or other competent  
18 authority, be eligible for Secret clearance or higher as  
19 required, and agree in writing to comply with the orders,  
20 rules, and regulations of this Military Commission.

21 If a civilian lawyer represents you, your Detailed  
22 Defense Counsel will continue to represent you as well, unless  
23 you specifically waive the right to be represented by Detailed

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1 Defense Counsel.

2 Do you understand what I have just told you?

3 The accused refuses to answer.

4 Do you have any question about your right to

5 counsel before this Commission?

6 The accused refuses to answer.

7 Do you desire to be represented by Lieutenant

8 Colonel Thomas and Mr. Connell?

9 The accused refuses to answer.

10 Do you desire any other qualified counsel?

11 The accused refuses to answer.

12 Mr. Ali, in the event that counsel may disagree on

13 a matter concerning your representation, I need you to

14 designate the lead counsel who will speak for you and the

15 defense team.

16 Whom do you designate as lead counsel?

17 The accused refuses to answer.

18 Given Mr. Ali's refusal to make an explicit

19 counsel election, he will have his detailed counsel,

20 Lieutenant Colonel Thomas, and his learned counsel,

21 Mr. Connell.

22 DC [MR. CONNELL]: Sir, I wish to correct the record on

23 one point in which the Commission observed earlier that

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1 someone using a general -- made a general observation some  
2 people had their earphones on at some point and had taken them  
3 off. I want the record to reflect Mr. al-Baluchi at no point  
4 had on his earphones.

5 MJ [COL POHL]: Mr. Connell, is there anything you think  
6 I need to go over with him ----

7 DC [MR. CONNELL]: No, sir.

8 MJ [COL POHL]: ---- about the earphones thus far?

9 DC [MR. CONNELL]: No, sir, I don't think there is  
10 anything further.

11 MJ [COL POHL]: Mr. Hawsawi, pursuant to the Rules for  
12 Military Commissions, you are represented by Commander Ruiz,  
13 the Detailed Defense Counsel.

14 Do you understand this?

15 The accused refuses to answer.

16 Detailed Defense Counsel is provided to you free  
17 of charge.

18 Do you understand this?

19 The accused refuses to answer.

20 In addition to Detailed Defense Counsel, you have  
21 the right to at least one counsel learned in applicable law  
22 related to capital cases and who, if necessary, may be a  
23 civilian and compensated in accordance with regulations

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1 prescribed by the Secretary of Defense. Commander Ruiz also  
2 has special experience and training in which a death sentence  
3 may be adjudged and will serve as both detailed and learned  
4 counsel in your case if you so desire.

5 Do you understand this?

6 The accused refuses to answer.

7 You also have the option to request an individual  
8 military counsel. You may ask the Chief Defense Counsel to  
9 provide any attorney from his office that you wish if that  
10 attorney is reasonably available. If your request for  
11 individual military counsel is approved, Commander Ruiz will  
12 normally no longer be available to represent you.

13 You may request the Chief Defense Counsel to let  
14 your Detailed Defense Counsel stay on the case, but your  
15 request will not have to be granted.

16 Do you understand this?

17 The accused refuses to answer.

18 In addition to Detailed Defense Counsel, you may  
19 be represented by a qualified civilian lawyer. A civilian  
20 lawyer would represent you at no expense to the government.  
21 To be qualified, he or she must be a U.S. citizen, admitted to  
22 the practice of law in a state, district, territory or  
23 possession of the United States, or a federal court, may not

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1 have been the subject of disqualifying action by a bar or  
2 other competent authority, be eligible for a Secret clearance  
3 or higher as required, and agree in writing to comply with the  
4 orders, rules and regulations of these Military Commissions.

5 If a civilian lawyer represents you, your Detailed  
6 Defense Counsel will continue to represent you as well unless  
7 you specifically waive the right to be represented by Detailed  
8 Defense Counsel.

9 Do you understand what I have just told you?

10 The accused refuses to answer.

11 Do you have any questions about your right to  
12 counsel before this Commission?

13 The accused refuses to answer.

14 Do you desire to be represented by Commander Ruiz?

15 The accused refuses to answer.

16 Do you want any other qualified counsel?

17 The accused refuses to answer.

18 Given the accused's failure to explicitly state  
19 who he wants as counsel and he refused to answer the questions  
20 of counsel, Commander Ruiz will serve as detailed and learned  
21 counsel.

22 Commander Ruiz, you are standing. Does that mean  
23 you want to say something?

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1 DC [CDR RUIZ]: Yes, Your Honor. Your Honor, with  
2 respect to your last question to Mr. Hawsawi, whether he wants  
3 to be represented by any other qualified counsel, I would like  
4 at this time to submit into the appellate record Mr. Hawsawi's  
5 request for additional capital qualified counsel, civilian  
6 David Ruhnke, along with the Chief Defense Counsel  
7 certification of Mr. Ruhnke as a death-penalty-qualified  
8 lawyer, as well as the Convening Authority's, Mr. Bruce  
9 MacDonald's, denial of that request.

10 I am authorized by Mr. Hawsawi to indicate to the  
11 court that at this time he would like to be represented by a  
12 civilian death-penalty-qualified lawyer. And I would like to  
13 mark this as the next appellate exhibit in order and submit it  
14 for the Court's consideration, as we feel it is directly  
15 relevant and material to the questions the court is asking at  
16 this point in terms of election of counsel.

17 Your Honor just asked Mr. Hawsawi if he wanted to  
18 be represented by additional qualified counsel; the answer is  
19 yes. We want to protect the record and indicate that request  
20 has been made and denied. But for that denial, Mr. Hawsawi at  
21 this point would indicate to Your Honor, in response to that  
22 question, that yes, he would.

23 MJ [COL POHL]: Okay. You want to make it part of the

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1 record, your appellate exhibit?

2 DC [CDR RUIZ]: I would like to, sir.

3 MJ [COL POHL]: As part of the appellate or any record  
4 is Mr. Hawsawi's specific response to my question to him; so  
5 what you have in writing is fine, your proffer is fine, but I  
6 have to hear it from him. If he wants other qualified  
7 counsel, he is free to answer the question. He chose not to.

8 DC [CDR RUIZ]: Mr. Hawsawi is authorized to speak  
9 through counsel ----

10 MJ [COL POHL]: Not on that issue.

11 DC [CDR RUIZ]: ---- is what I'm telling the court.

12 MJ [COL POHL]: You put it in the record.

13 DC [CDR RUIZ]: I'll put it in the record.

14 MJ [COL POHL]: He was asked, he had the option to ----

15 DC [CDR RUIZ]: He's asking it through me.

16 MJ [COL POHL]: I'm sorry?

17 DC [CDR RUIZ]: He is asking through counsel.

18 MJ [COL POHL]: It doesn't work that way. I mean, I  
19 understand what you are saying, but this is his request for  
20 counsel. That is personal to the accused, and it is a very  
21 simple question. He can choose to answer it if he so chooses.  
22 He chose not to.

23 Be all that as it may, you made your record. We

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1 will make that as the next exhibit. Treat it as one appellate  
2 exhibit. That will be Appellate Exhibit 24.

3 DC [CDR RUIZ]: That has been marked Appellate  
4 Exhibit 24, again, the defense request to the Convening  
5 Authority for civilian death-penalty-qualified lawyer  
6 Mr. David Ruhnke and Chief Defense Counsel certification as  
7 well as the Convening Authority's denial. I have conforming  
8 copies for the prosecution, and I am delivering them a copy of  
9 that request at this time.

10 MJ [COL POHL]: I'll tell you what, we have been going  
11 on for a little bit now. I know it is awkward. We will take  
12 a ten-minute recess.

13 [The Military Commission recessed at 1123, 5 May 2012.]

14  
15  
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TEAM HAWSAWI  
COURT CLOTHING INVENTORY

The item(s) listed below are prepared for the sole and specific use of Mr. Mustafa al Hawsawi (ISN 10011) for court appearances. The undersigned acknowledge transfer and receipt of said items in good condition.

ITEM	QTY
Jump suit, orange, cotton	1
Shirt, orange, Rayon, collared, short sleeve	1
Shirt, orange, collarless, short sleeve (BASIC brand)	1
A'bayah (Arabic men's Formal Gown), long sleeve, white with stripes	1
Kaffiyah (men's Head Dress) white	1
T-shirt, white	3
Undershirt, white, men's	1
Prayer Rug, brown/beige with Bag, beige/gold	1
Masbaha beads, blue	1
Masbaha beads, purple/brown	1
Masbaha bead bag, gold	1

3 [Redacted]

Print Rank, Name

transferred to

3 [Redacted]

on

4 May 12  
Date

3 [Redacted]

3 [Redacted]



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U.S. Department of Justice

Office of Legal Counsel

Office of the Principal Deputy Assistant Attorney General

Washington, D.C. 20530

May 10, 2005

**MEMORANDUM FOR JOHN A. RIZZO**  
**SENIOR DEPUTY GENERAL COUNSEL, CENTRAL INTELLIGENCE AGENCY**

*Re: Application of 18 U.S.C. §§ 2340-2340A to the Combined Use of Certain Techniques  
 in the Interrogation of High Value al Qaeda Detainees*

In our Memorandum for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency, from Steven G. Bradbury, Principal Deputy Assistant Attorney General, Office of Legal Counsel, *Re: Application of 18 U.S.C. §§ 2340-2340A to Certain Techniques That May Be Used in the Interrogation of a High Value al Qaeda Detainee* (May 10, 2005) ("*Techniques*"), we addressed the application of the anti-torture statute, 18 U.S.C. §§ 2340-2340A, to certain interrogation techniques that the CIA might use in the questioning of a specific al Qaeda operative. There, we considered each technique individually. We now consider the application of the statute to the use of these same techniques in combination. Subject to the conditions and limitations set out here and in *Techniques*, we conclude that the authorized combined use of these specific techniques by adequately trained interrogators would not violate sections 2340-2340A.

*Techniques*, which set out our general interpretation of the statutory elements, guides us here.<sup>1</sup> While referring to the analysis provided in that opinion, we do not repeat it, but instead

<sup>1</sup> As noted in *Techniques*, the Criminal Division of the Department of Justice is satisfied that our general interpretation of the legal standards under sections 2340-2340A, found in *Techniques*, is consistent with its concurrence in our Memorandum for James B. Comey, Deputy Attorney General, from Daniel Levin, Acting Assistant Attorney General, Office of Legal Counsel, *Re: Legal Standards Applicable Under 18 U.S.C. §§ 2340-2340A* (Dec. 30, 2004). In the present memorandum, we address only the application of 18 U.S.C. §§ 2340-2340A to combinations of interrogation techniques. Nothing in this memorandum or in our prior advice to the CIA should be read to suggest that the use of these techniques would conform to the requirements of the Uniform Code of Military Justice that governs members of the Armed Forces or to United States obligations under the Geneva Conventions in circumstances where those Conventions would apply. We do not address the possible application of article 16 of the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, S. Treaty Doc. No. 100-20, 1465 U.N.T.S. 85 (entered into force for U.S. Nov. 20,

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presume a familiarity with it. Furthermore, in referring to the individual interrogation techniques whose combined use is our present subject, we mean those techniques as we described them in *Techniques*, including all of the limitations, presumptions, and safeguards described there.

One overarching point from *Techniques* bears repeating: Torture is abhorrent and universally repudiated, *see Techniques* at 1, and the President has stated that the United States will not tolerate it. *Id.* at 1-2 & n.2 (citing Statement on United Nations International Day in Support of Victims of Torture, 40 Weekly Comp. Pres. Doc. 1167-68 (July 5, 2004)). In *Techniques*, we accordingly exercised great care in applying sections 2340-2340A to the individual techniques at issue; we apply the same degree of care in considering the combined use of these techniques.

## I.

Under 18 U.S.C. § 2340A, it is a crime to commit, attempt to commit, or conspire to commit torture outside the United States. "Torture" is defined as "an act committed by a person acting under color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control." 18 U.S.C. § 2340(1). "Severe mental pain or suffering" is defined as "the prolonged mental harm caused by or resulting from" any of four predicate acts. *Id.* § 2340(2). These acts are (1) "the intentional infliction or threatened infliction of severe physical pain or suffering"; (2) "the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality"; (3) "the threat of imminent death"; and (4) "the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality."

In *Techniques*, we concluded that the individual authorized use of several specific interrogation techniques, subject to a variety of limitations and safeguards, would not violate the statute when employed in the interrogation of a specific member of al Qaeda, though we concluded that at least in certain respects two of the techniques presented substantial questions under sections 2340-2340A. The techniques that we analyzed were dietary manipulation, nudity, the attention grasp, walling, the facial hold, the facial slap or insult slap, the abdominal slap, cramped confinement, wall standing, stress positions, water dousing, extended sleep deprivation, and the "waterboard." *Techniques* at 7-15.

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1994), nor do we address any question relating to conditions of confinement or detention, as distinct from the interrogation of detainees. We stress that our advice on the application of sections 2340-2340A does not represent the policy views of the Department of Justice concerning interrogation practices. Finally, we note that section 6057(a) of H.R. 1268 (109th Cong. 1st Sess.), if it becomes law, would forbid expending or obligating funds made available by that bill "to subject any person in the custody or under the physical control of the United States to torture," but because the bill would define "torture" to have "the meaning given that term in section 2340(1) of title 18, United States Code," § 6057(b)(1), the provision (to the extent it might apply here at all) would merely reaffirm the preexisting prohibitions on torture in sections 2340-2340A.

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*Techniques* analyzed only the use of these techniques individually. As we have previously advised, however, "courts tend to take a totality-of-the-circumstances approach and consider an entire course of conduct to determine whether torture has occurred." Memorandum for John Rizzo, Acting General Counsel, Central Intelligence Agency, from Jay S. Bybee, Assistant Attorney General, Office of Legal Counsel, *Re: Interrogation of al Qaeda Operative* at 9 (Aug. 1, 2002) ("*Interrogation Memorandum*") (TS). A complete analysis under sections 2340-2340A thus entails an examination of the combined effects of any techniques that might be used.

In conducting this analysis, there are two additional areas of general concern. First, it is possible that the application of certain techniques might render the detainee unusually susceptible to physical or mental pain or suffering. If that were the case, use of a second technique that would not ordinarily be expected to—and could not reasonably be considered specifically intended to—cause severe physical or mental pain or suffering by itself might in fact cause severe physical or mental pain or suffering because of the enhanced susceptibility created by the first technique. Depending on the circumstances, and the knowledge and mental state of the interrogator, one might conclude that severe pain or suffering was specifically intended by the application of the second technique to a detainee who was particularly vulnerable because of the application of the first technique. Because the use of these techniques in combination is intended to, and in fact can be expected to, physically wear down a detainee, because it is difficult to assess as to a particular individual whether the application of multiple techniques renders that individual more susceptible to physical pain or suffering, and because sleep deprivation, in particular, has a number of documented physiological effects that, in some circumstances, could be problematic it is important that all participating CIA personnel, particularly interrogators and personnel of the CIA Office of Medical Services ("OMS"), be aware of the potential for enhanced susceptibility to pain and suffering from each interrogation technique. We also assume that there will be active and ongoing monitoring by medical and psychological personnel of each detainee who is undergoing a regimen of interrogation, and active intervention by a member of the team or medical staff as necessary, so as to avoid the possibility of severe physical or mental pain or suffering within the meaning of 18 U.S.C. §§ 2340-2340A as a result of such combined effects.

Second, it is possible that certain techniques that do not themselves cause severe physical or mental pain or suffering might do so in combination, particularly when used over the 30-day interrogation period with which we deal here. Again, depending on the circumstances, and the mental state of the interrogator, their use might be considered to be specifically intended to cause such severe pain or suffering. This concern calls for an inquiry into the totality of the circumstances, looking at which techniques are combined and how they are combined.

Your office has outlined the manner in which many of the individual techniques we previously considered could be combined in *Background Paper on CIA's Combined Use of Interrogation Techniques* (undated, but transmitted Dec. 30, 2004) ("*Background Paper*"). The *Background Paper*, which provides the principal basis for our analysis, first divides the process of interrogation into three phases: "Initial Conditions," "Transition to Interrogation," and "Interrogation." *Id.* at 1. After describing these three phases, *see id.* at 1-9, the *Background Paper* "provides a look at a prototypical interrogation with an emphasis on the application of

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interrogation techniques, in combination and separately," *id.* at 9-18. The *Background Paper* does not include any discussion of the waterboard; however, you have separately provided to us a description of how the waterboard may be used in combination with other techniques, particularly dietary manipulation and sleep deprivation. See Fax for Steven G. Bradbury, Principal Deputy Assistant Attorney General, Office of Legal Counsel, from [REDACTED] Assistant General Counsel, CIA, at 3-4 (Apr. 22, 2005) ("April 22 [REDACTED] Fax").

### *Phases of the Interrogation Process*

The first phase of the interrogation process, "Initial Conditions," does not involve interrogation techniques, and you have not asked us to consider any legal question regarding the CIA's practices during this phase. The "Initial Conditions" nonetheless set the stage for use of the interrogation techniques, which come later.<sup>2</sup>

According to the *Background Paper*, before being flown to the site of interrogation, a detainee is given a medical examination. He then is "securely shackled and is deprived of sight and sound through the use of blindfolds, earmuffs, and hoods" during the flight. *Id.* at 2. An on-board medical officer monitors his condition. Security personnel also monitor the detainee for signs of distress. Upon arrival at the site, the detainee "finds himself in complete control of Americans" and is subjected to "precise, quiet, and almost clinical" procedures designed to underscore "the enormity and suddenness of the change in environment, the uncertainty about what will happen next, and the potential dread [a detainee] may have of US custody." *Id.* His head and face are shaved; his physical condition is documented through photographs taken while he is nude; and he is given medical and psychological interviews to assess his condition and to make sure there are no contraindications to the use of any particular interrogation techniques. See *id.* at 2-3.

The detainee then enters the next phase, the "Transition to Interrogation." The interrogators conduct an initial interview, "in a relatively benign environment," to ascertain whether the detainee is willing to cooperate. The detainee is "normally clothed but seated and shackled for security purposes." *Id.* at 3. The interrogators take "an open, non-threatening approach," but the detainee "would have to provide information on actionable threats and location information on High-Value Targets at large—not lower-level information—for interrogators to continue with [this] neutral approach." *Id.* If the detainee does not meet this "very high" standard, the interrogators submit a detailed interrogation plan to CIA headquarters

<sup>2</sup> Although the *OMS Guidelines on Medical and Psychological Support to Detainee Rendition, Interrogation and Detention* (Dec. 2004) ("*OMS Guidelines*") refer to the administration of sedatives during transport if necessary to protect the detainee or the rendition team, *id.* at 4-5, the *OMS Guidelines* do not provide for the use of sedatives for interrogation. The *Background Paper* does not mention the administration of any drugs during the detainee's transportation to the site of the interrogation or at any other time, and we do not address any such administration. OMS, we understand, is unaware of any use of sedation during the transport of a detainee in the last two years and states that the interrogation program does not use sedation or medication for the purpose of interrogation. We caution that any use of sedatives should be carefully evaluated, including under 18 U.S.C. § 2340(2)(B). For purposes of our analysis, we assume that no drugs are administered during the relevant period or that there are no ongoing effects from any administration of any drugs; if that assumption does not hold, our analysis and conclusions could change.

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for approval. If the medical and psychological assessments find no contraindications to the proposed plan, and if senior CIA officers at headquarters approve some or all of the plan through a cable transmitted to the site of the interrogation, the interrogation moves to the next phase. *Id.*<sup>3</sup>

Three interrogation techniques are typically used to bring the detainee to "a baseline, dependent state," "demonstrat[ing] to the [detainee] that he has no control over basic human needs" and helping to make him "perceive and value his personal welfare, comfort, and immediate needs more than the information he is protecting." *Id.* at 4. The three techniques used to establish this "baseline" are nudity, sleep deprivation (with shackling and, at least at times, with use of a diaper), and dietary manipulation. These techniques, which *Techniques* described in some detail, "require little to no physical interaction between the detainee and interrogator." *Background Paper* at 5.

Other techniques, which "require physical interaction between the interrogator and detainee," are characterized as "corrective" and "are used principally to correct, startle, or ... achieve another enabling objective with the detainee." *Id.* These techniques "are not used simultaneously but are often used interchangeably during an individual interrogation session." *Id.* The insult slap is used "periodically throughout the interrogation process when the interrogator needs to immediately correct the detainee or provide a consequence to a detainee's response or non-response." *Id.* at 5-6. The insult slap "can be used in combination with water dousing or kneeling stress positions"—techniques that are not characterized as "corrective." *Id.* at 6. Another corrective technique, the abdominal slap, "is similar to the insult slap in application and desired result" and "provides the variation necessary to keep a high-level of unpredictability in the interrogation process." *Id.* The abdominal slap may be simultaneously, combined with water dousing, stress positions, and wall standing. A third corrective technique, the facial hold, "is used sparingly throughout interrogation." *Id.* It is not painful; but "demonstrates the interrogator's control over the [detainee]." *Id.* It too may be simultaneously combined with water dousing, stress positions, and wall standing. *Id.* Finally, the attention grasp "may be used several times in the same interrogation" and may be simultaneously combined with water dousing or kneeling stress positions. *Id.*

Some techniques are characterized as "coercive." These techniques "place the detainee in more physical and psychological stress." *Id.* at 7. Coercive techniques "are typically not used

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<sup>3</sup> The CIA maintains certain "detention conditions" at all of its detention facilities. (These conditions "are not interrogation techniques," *Id.* at 4, and you have not asked us to assess their lawfulness under the statute.) The detainee is "exposed to white noise/loud sounds (not to exceed 79 decibels) and constant light during portions of the interrogation process." *Id.* These conditions enhance security. The noise prevents the detainee from overhearing conversations of staff members, precludes him from picking up "auditory clues" about his surroundings, and disrupts any efforts to communicate with other detainees. *Id.* The light provides better conditions for security and for monitoring by the medical and psychological staff and the interrogators. Although we do not address the lawfulness of using white noise (not to exceed 79 decibels) and constant light, we note that according to materials you have furnished to us, (1) the Occupational Safety and Health Administration has determined that there is no risk of permanent hearing loss from continuous, 24-hour per day exposure to noise of up to 82 decibels, and (2) detainees typically adapt fairly quickly to the constant light and it does not interfere unduly with their ability to sleep. See Fax for Dan Levin, Acting Assistant Attorney General, Office of Legal Counsel, from [REDACTED] Assistant General Counsel, Central Intelligence Agency at 3 (Jan. 4, 2005) ("Fax").

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in combination, although some combined use is possible." *Id.* Walling "is one of the most effective interrogation techniques because it wears down the [detainee] physically, heightens uncertainty in the detainee about what the interrogator may do to him, and creates a sense of dread when the [detainee] knows he is about to be walled again." *Id.*<sup>4</sup> A detainee "may be walled one time (one impact with the wall) to make a point or twenty to thirty times consecutively when the interrogator requires a more significant response to a question," and "will be walled multiple times" during a session designed to be intense. *Id.* Walling cannot practically be used at the same time as other interrogation techniques.

Water temperature and other considerations of safety established by OMS limit the use of another coercive technique, water dousing. *See id.* at 7-8. The technique "may be used frequently within those guidelines." *Id.* at 8. As suggested above, interrogators may combine water dousing with other techniques, such as stress positions, wall standing, the insult slap, or the abdominal slap. *See id.* at 8.

The use of stress positions is "usually self-limiting in that temporary muscle fatigue usually leads to the [detainee's] being unable to maintain the stress position after a period of time." *Id.* Depending on the particular position, stress positions may be combined with water dousing, the insult slap, the facial hold, and the attention grasp. *See id.* Another coercive technique, wall standing, is "usually self-limiting" in the same way as stress positions. *Id.* It may be combined with water dousing and the abdominal slap. *See id.* OMS guidelines limit the technique of cramped confinement to no more than eight hours at a time and 18 hours a day, and confinement in the "small box" is limited to two hours. *Id.* Cramped confinement cannot be used in simultaneous combination with corrective or other coercive techniques.

We understand that the CIA's use of all these interrogation techniques is subject to ongoing monitoring by interrogation team members who will direct that techniques be discontinued if there is a deviation from prescribed procedures and by medical and psychological personnel from OMS who will direct that any or all techniques be discontinued if in their professional judgment the detainee may otherwise suffer severe physical or mental pain or suffering. *See Techniques* at 6-7.

#### *A Prototypical Interrogation*

In a "prototypical interrogation," the detainee begins his first interrogation session stripped of his clothes, shackled, and hooded, with the walling collar over his head and around

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<sup>4</sup> Although walling "wears down the [detainee] physically," *Background Paper* at 7, and undoubtedly may startle him, we understand that it is not significantly painful. The detainee hits "a flexible false wall," designed "to create a loud sound when the individual hits it" and thus to cause "shock and surprise." *Interrogation Memorandum* at 2. But the detainee's "head and neck are supported with a rolled hood or towel that provides a c-collar effect to help prevent whiplash"; it is the detainee's shoulder blades that hit the wall, and the detainee is allowed to rebound from the flexible wall in order to reduce the chances of any injury. *See id.* You have informed us that a detainee is expected to feel "dread" at the prospect of walling because of the shock and surprise caused by the technique and because of the sense of powerlessness that comes from being roughly handled by the interrogators, not because the technique causes significant pain.

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his neck. *Background Paper* at 9-10. The interrogators remove the hood and explain that the detainee can improve his situation by cooperating and may say that the interrogators "will do what it takes to get important information." *Id.*<sup>5</sup> As soon as the detainee does anything inconsistent with the interrogators' instructions, the interrogators use an insult slap or abdominal slap. They employ walling if it becomes clear that the detainee is not cooperating in the interrogation. This sequence "may continue for several more iterations as the interrogators continue to measure the [detainee's] resistance posture and apply a negative consequence to [his] resistance efforts." *Id.* The interrogators and security officers then put the detainee into position for standing sleep deprivation, begin dietary manipulation through a liquid diet, and keep the detainee nude (except for a diaper). *See id.* at 10-11. The first interrogation session, which could have lasted from 30 minutes to several hours, would then be at an end. *See id.* at 11.

If the interrogation team determines there is a need to continue, and if the medical and psychological personnel advise that there are no contraindications, a second session may begin. *See id.* at 12. The interval between sessions could be as short as an hour or as long as 24 hours. *See id.* at 11. At the start of the second session, the detainee is released from the position for standing sleep deprivation, is hooded, and is positioned against the walling wall, with the walling collar over his head and around his neck. *See id.* Even before removing the hood, the interrogators use the attention grasp to startle the detainee. The interrogators take off the hood and begin questioning. If the detainee does not give appropriate answers to the first questions, the interrogators use an insult slap or abdominal slap. *See id.* They employ walling if they determine that the detainee "is intent on maintaining his resistance posture." *Id.* at 13. This sequence "may continue for multiple iterations as the interrogators continue to measure the [detainee's] resistance posture." *Id.* The interrogators then increase the pressure on the detainee by using a hose to douse the detainee with water for several minutes. They stop and start the dousing as they continue the interrogation. *See id.* They then end the session by placing the detainee into the same circumstances as at the end of the first session: the detainee is in the standing position for sleep deprivation, is nude (except for a diaper), and is subjected to dietary manipulation. Once again, the session could have lasted from 30 minutes to several hours. *See id.*

Again, if the interrogation team determines there is a need to continue, and if the medical and psychological personnel find no contraindications, a third session may follow. The session begins with the detainee positioned as at the beginning of the second. *See id.* at 14. If the detainee continues to resist, the interrogators continue to use walling and water dousing. The corrective techniques—the insult slap, the abdominal slap, the facial hold, the attention grasp—"may be used several times during this session based on the responses and actions of the [detainee]." *Id.* The interrogators integrate stress positions and wall standing into the session. Furthermore, "[i]ntense questioning and walling would be repeated multiple times." *Id.* Interrogators "use one technique to support another." *Id.* For example, they threaten the use of walling unless the detainee holds a stress position, thus inducing the detainee to remain in the position longer than he otherwise would. At the end of the session, the interrogators and security

<sup>5</sup> We address the effects of this statement below at pp. 18-19.

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personnel place the detainee into the same circumstances as at the end of the first two sessions, with the detainee subject to sleep deprivation, nudity, and dietary manipulation. *Id.*

In later sessions, the interrogators use those techniques that are proving most effective and drop the others. Sleep deprivation "may continue to the 70 to 120 hour range, or possibly beyond for the hardest resisters, but in no case exceed the 180-hour time limit." *Id.* at 15.<sup>6</sup> If the medical or psychological personnel find contraindications, sleep deprivation will end earlier. *See id.* at 15-16. While continuing the use of sleep deprivation, nudity, and dietary manipulation, the interrogators may add cramped confinement. As the detainee begins to cooperate, the interrogators "begin gradually to decrease the use of interrogation techniques." *Id.* at 16. They may permit the detainee to sit, supply clothes, and provide more appetizing food. *See id.*

The entire process in this "prototypical interrogation" may last 30 days. If additional time is required and a new approval is obtained from headquarters, interrogation may go longer than 30 days. Nevertheless, "[o]n average, the actual use of interrogation techniques covers a period of three to seven days, but can vary upwards to fifteen days based on the resilience of the [detainee]." *Id.* As in *Techniques*, our advice here is limited to an interrogation process lasting no more than 30 days. *See Techniques* at 5.

#### *Use of the Waterboard in Combination with Other Techniques*

We understand that for a small number of detainees in very limited circumstances, the CIA may wish to use the waterboard technique. You have previously explained that the waterboard technique would be used only if: (1) the CIA has credible intelligence that a terrorist attack is imminent; (2) there are "substantial and credible indicators the subject has actionable intelligence that can prevent, disrupt or delay this attack"; and (3) other interrogation methods have failed or are unlikely to yield actionable intelligence in time to prevent the attack. *See* Attachment to Letter from John A. Rizzo, Acting General Counsel, CIA, to Daniel Levin, Acting Assistant Attorney General, Office of Legal Counsel (Aug. 2, 2004). You have also informed us that the waterboard may be approved for use with a given detainee only during, at most, one single 30-day period, and that during that period, the waterboard technique may be used on no more than five days. We further understand that in any 24-hour period, interrogators may use no more than two "sessions" of the waterboard on a subject—with a "session" defined to mean the time that the detainee is strapped to the waterboard—and that no session may last more than two hours. Moreover, during any session, the number of individual applications of water lasting 10 seconds or longer may not exceed six. The maximum length of any application of water is 40 seconds (you have informed us that this maximum has rarely been reached). Finally, the total cumulative time of all applications of whatever length in a 24-hour period may not exceed 12 minutes. *See* Letter from [redacted] Associate General Counsel, CIA, to Dan Levin, Acting Assistant Attorney General, Office of Legal Counsel, at 1-2 (Aug. 19, 2004).

<sup>6</sup> As in *Techniques*, our advice here is restricted to one application of no more than 180 hours of sleep deprivation.

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You have advised us that in those limited cases where the waterboard would be used, it would be used only in direct combination with two other techniques, dietary manipulation and sleep deprivation. See April 22 ~~NOFORN~~ Fax at 3-4. While an individual is physically on the waterboard, the CIA does not use the attention grasp, walling, the facial hold, the facial or insult slap, the abdominal slap, cramped confinement, wall standing, stress positions, or water dousing, though some or all of these techniques may be used with the individual before the CIA needs to resort to the waterboard, and we understand it is possible that one or more of these techniques might be used on the same day as a waterboard session, but separately from that session and not in conjunction with the waterboard. See *id.* at 3.

As we discussed in *Techniques*, you have informed us that an individual undergoing the waterboard is always placed on a fluid diet before he may be subjected to the waterboard in order to avoid aspiration of food matter. The individual is kept on the fluid diet throughout the period the waterboard is used. For this reason, and in this way, the waterboard is used in combination with dietary manipulation. See April 22 ~~NOFORN~~ Fax at 3.

You have also described how sleep deprivation may be used prior to and during the waterboard session. *Id.* at 4. We understand that the time limitation on use of sleep deprivation, as set forth in *Techniques*, continues to be strictly monitored and enforced when sleep deprivation is used in combination with the waterboard (as it is when used in combination with other techniques). See April 22 ~~NOFORN~~ Fax at 4. You have also informed us that there is no evidence in literature or experience that sleep deprivation exacerbates any harmful effects of the waterboard, though it does reduce the detainee's will to resist and thereby contributes to the effectiveness of the waterboard as an interrogation technique. *Id.* As in *Techniques*, we understand that in the event the detainee were perceived to be unable to withstand the effects of the waterboard for any reason, any member of the interrogation team has the obligation to intervene and, if necessary, to halt the use of the waterboard. See April 22 ~~NOFORN~~ Fax at 4.

## II.

The issue of the combined effects of interrogation techniques raises complex and difficult questions and comes to us in a less precisely defined form than the questions treated in our earlier opinions about individual techniques. In evaluating individual techniques, we turned to a body of experience developed in the use of analogous techniques in military training by the United States, to medical literature, and to the judgment of medical personnel. Because there is less certainty and definition about the use of techniques in combination, it is necessary to draw more inferences in assessing what may be expected. You have informed us that, although "the exemplar [that is, the prototypical interrogation] is a fair representation of how these techniques are actually employed," "there is no template or script that states with certainty when and how these techniques will be used in combination during interrogation." *Background Paper* at 17. Whether any other combination of techniques would, in the relevant senses, be like the ones presented—whether the combination would be no more likely to cause severe physical or mental pain or suffering within the meaning of sections 2340-2340A—would be a question that cannot be assessed in the context of the present legal opinion. For that reason, our advice does not extend to combinations of techniques unlike the ones discussed here. For the same reason, it is especially important that the CIA use great care in applying these various techniques in

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combination in a real-world scenario, and that the members of the interrogation team, and the attendant medical staff, remain watchful for indications that the use of techniques in combination may be having unintended effects, so that the interrogation regimen may be altered or halted, if necessary, to ensure that it will not result in severe physical or mental pain or suffering to any detainee in violation of 18 U.S.C. §§ 2340-2340A.

Finally, in both of our previous opinions about specific techniques, we evaluated the use of those techniques on particular identified individuals. Here, we are asked to address the combinations without reference to any particular detainee. As is relevant here, we know only that an enhanced interrogation technique, such as most of the techniques at issue in *Techniques*, may be used on a detainee only if medical and psychological personnel have determined that he is not likely, as a result, to experience severe physical or mental pain or suffering. *Techniques* at 5. Once again, whether other detainees would, in the relevant ways, be like the ones previously at issue would be a factual question we cannot now decide. Our advice, therefore, does not extend to the use of techniques on detainees unlike those we have previously considered. Moreover, in this regard, it is also especially important, as we pointed out in *Techniques* with respect to certain techniques, *see, e.g., id.* at 37 (discussing sleep deprivation), that the CIA will carefully assess the condition of each individual detainee and that the CIA's use of these techniques in combination will be sensitive to the individualized physical condition and reactions of each detainee, so that the regimen of interrogation would be altered or halted, if necessary, in the event of unanticipated effects on a particular detainee.

Subject to these cautions and to the conditions, limitations, and safeguards set out below and in *Techniques*, we nonetheless can reach some conclusions about the combined use of these techniques. Although this is a difficult question that will depend on the particular detainee, we do not believe that the use of the techniques in combination as you have described them would be expected to inflict "severe physical or mental pain or suffering" within the meaning of the statute. 18 U.S.C. § 2340(1). Although the combination of interrogation techniques will wear a detainee down physically, we understand that the principal effect, as well as the primary goal, of interrogation using these techniques is psychological—"to create a state of learned helplessness and dependence conducive to the collection of intelligence in a predictable, reliable, and sustainable manner," *Background Paper* at 1—and numerous precautions are designed to avoid inflicting "severe physical or mental pain or suffering."

For present purposes, we may divide "severe physical or mental pain or suffering" into three categories: "severe physical . . . pain," "severe physical . . . suffering," and "severe . . . mental pain or suffering" (the last being a defined term under the statute). *See Techniques* at 22-26; Memorandum for James B. Comey, Deputy Attorney General, from Daniel Levin, Acting Assistant Attorney General, Office of Legal Counsel, *Re: Legal Standards Applicable Under 18 U.S.C. §§ 2340-2340A* (Dec. 30, 2004).

As explained below, any physical pain resulting from the use of these techniques, even in combination, cannot reasonably be expected to meet the level of "severe physical pain" contemplated by the statute. We conclude, therefore, that the authorized use in combination of these techniques by adequately trained interrogators, as described in the *Background Paper* and the April 22 [REDACTED] Fax, could not reasonably be considered specifically intended to do so.

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Moreover, although it presents a closer question under sections 2340-2340A, we conclude that the combined use of these techniques also cannot reasonably be expected to—and their combined use in the authorized manner by adequately trained interrogators could not reasonably be considered specifically intended to—cause severe physical suffering. Although two techniques, extended sleep deprivation and the waterboard, may involve a more substantial risk of physical distress, nothing in the other specific techniques discussed in the *Background Paper* and the April 22 [REDACTED] Fax, or, as we understand it, in the CIA's experience to date with the interrogations of more than two dozen detainees (three of whose interrogations involved the use of the waterboard), would lead to the expectation that any physical discomfort from the combination of sleep deprivation or the waterboard and other techniques would involve the degree of intensity and duration of physical distress sufficient to constitute severe physical suffering under the statute. Therefore, the use of the technique could not reasonably be viewed as specifically intended to cause severe physical suffering. We stress again, however, that these questions concerning whether the combined effects of different techniques may rise to the level of physical suffering within the meaning of sections 2340-2340A are difficult ones, and they reinforce the need for close and ongoing monitoring by medical and psychological personnel and by all members of the interrogation team and active intervention if necessary.

Analyzing the combined techniques in terms of severe mental pain or suffering raises two questions under the statute. The first is whether the risk of hallucinations from sleep deprivation may become exacerbated when combined with other techniques, such that a detainee might be expected to experience "prolonged mental harm" from the combination of techniques. Second, the description in the *Background Paper* that detainees may be specifically told that interrogators will "do what it takes" to elicit information, *id.* at 10, raises the question whether this statement might qualify as a threat of infliction of severe physical pain or suffering or another of the predicate acts required for "severe mental pain or suffering" under the statute. After discussing both of those possibilities below, however, we conclude that the authorized use by adequately trained interrogators of the techniques in combination, as you have described them, would not reasonably be expected to cause prolonged mental harm and could not reasonably be considered specifically intended to cause severe mental pain or suffering. We stress that these possible questions about the combined use of the techniques under the statutory category of severe mental pain or suffering are difficult ones and they serve to reinforce the need for close and ongoing monitoring and active intervention if necessary.

#### *Severe Physical Pain*

Our two previous opinions have not identified any techniques that would inflict pain that approaches the "sever[ity]" required to violate the statute. A number of the techniques—dietary manipulation, nudity, sleep deprivation, the facial hold, and the attention grasp—are not expected to cause physical pain at all. See *Techniques* at 30-36. Others might cause some pain, but the level of pain would not approach that which would be considered "severe." These techniques are the abdominal slap, water dousing, various stress positions, wall standing, cramped confinement, walling, and the facial slap. See *id.* We also understand that the waterboard is not physically painful. *Id.* at 41. In part because none of these techniques would individually cause pain that even approaches the "severe" level required to violate the statute, the combined use of the techniques under the conditions outlined here would not be expected to—

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and we conclude that their authorized use by adequately trained interrogators could not reasonably be considered specifically intended to—reach that level.<sup>7</sup>

We recognize the theoretical possibility that the use of one or more techniques would make a detainee more susceptible to severe pain or that the techniques, in combination, would operate differently from the way they would individually and thus cause severe pain. But as we understand the experience involving the combination of various techniques, the OMS medical and psychological personnel have not observed any such increase in susceptibility. Other than the waterboard, the specific techniques under consideration in this memorandum—including sleep deprivation—have been applied to more than 25 detainees. See [REDACTED] Fax at 1-3. No apparent increase in susceptibility to severe pain has been observed either when techniques are used sequentially or when they are used simultaneously—for example, when an insult slap is simultaneously combined with water dousing or a kneeling stress position, or when wall standing is simultaneously combined with an abdominal slap and water dousing. Nor does experience show that, even apart from changes in susceptibility to pain, combinations of these techniques cause the techniques to operate differently so as to cause severe pain. OMS doctors and psychologists, moreover, confirm that they expect that the techniques, when combined as described in the *Background Paper* and in the April 22 [REDACTED] Fax, would not operate in a different manner from the way they do individually, so as to cause severe pain.

We understand that experience supports these conclusions even though the *Background Paper* does give examples where the distress caused by one technique would be increased by use of another. The “conditioning techniques”—nudity, sleep deprivation, and dietary manipulation—appear designed to wear down the detainee, physically and psychologically, and to allow other techniques to be more effective, see *Background Paper* at 5, 12; April 22 [REDACTED] Fax at 4; and “these [conditioning] techniques are used in combination in almost all cases,” *Background Paper* at 17. And, in another example, the threat of walling is used to cause a detainee to hold a stress position longer than he otherwise would. See *id.* at 14. The issue raised by the statute, however, is whether the techniques would be specifically intended to cause the detainee to experience “severe . . . pain.” 18 U.S.C. § 2340(1). In the case of the conditioning

<sup>7</sup> We are not suggesting that combinations or repetitions of acts that do not individually cause severe physical pain could not result in severe physical pain. Other than the repeated use of the “walling” technique, however, nothing in the *Background Paper* suggests the kind of repetition that might raise an issue about severe physical pain; and, in the case of walling, we understand that this technique involves a false, flexible wall and is not significantly painful, even with repetition. Our advice with respect to walling in the present memorandum is based on the understanding that the repetitive use of walling is intended only to increase the shock and drama of the technique, to wear down the detainee's resistance, and to disrupt expectations that he will not be treated with force, and that such use is not intended to, and does not in fact, cause severe physical pain to the detainee. Along these lines, we understand that the repeated use of the insult slap and the abdominal slap gradually reduces their effectiveness and that their use is therefore limited to times when the detainee's overt disrespect for the questioner requires immediate correction, when the detainee displays obvious efforts to misdirect or ignore the questioner, or when the detainee attempts to provide an obvious lie in response to a specific question. Our advice assumes that the interrogators will apply those techniques as designed and will not strike the detainee with excessive force or repetition in a manner that might result in severe physical pain. As to all techniques, our advice assumes that the use of the technique will be stopped if there is any indication that it is or may be causing severe physical pain to the detainee.

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techniques, the principal effect, as you have described it, is on the detainee's will to resist other techniques, rather than on the pain that the other techniques cause. See *Background Paper* at 5, 12; *April 22 [REDACTED] Fax* at 4. Moreover, the stress positions and wall standing, while inducing muscle fatigue, do not cause "severe physical . . . pain," and there is no reason to believe that a position, held somewhat longer than otherwise, would create such pain. See *Techniques* at 33-34.<sup>8</sup>

In any particular case, a combination of techniques might have unexpected results, just as an individual technique could produce surprising effects. But the *Background Paper* and the *April 22 [REDACTED] Fax*, as well as *Techniques*, describe a system of medical and psychological monitoring of the detainee that would very likely identify any such unexpected results as they begin to occur and would require an interrogation to be modified or stopped if a detainee is in danger of severe physical pain. Medical and psychological personnel assess the detainee before any interrogation starts. See, e.g., *Techniques* at 5. Physical and psychological evaluations are completed daily during any period in which the interrogators use enhanced techniques, including those at issue in *Techniques* (leaving aside dietary manipulation and sleep deprivation of less than 48 hours). See *id.* at 5-7. Medical and psychological personnel are on scene throughout the interrogation, and are physically present or are otherwise observing during many of the techniques. See *id.* at 6-7. These safeguards, which were critically important to our conclusions about individual techniques, are even more significant when techniques are combined.

In one specific context, monitoring the effects on detainees appears particularly important. The *Background Paper* and the *April 22 [REDACTED] Fax* illustrate that sleep deprivation is a central part of the "prototypical interrogation." We noted in *Techniques* that extended sleep deprivation may cause a small decline in body temperature and increased food consumption. See *Techniques* at 33-34. Water dousing and dietary manipulation and perhaps even nudity may thus raise dangers of enhanced susceptibility to hypothermia or other medical conditions for a detainee undergoing sleep deprivation. As in *Techniques*, we assume that medical personnel will be aware of these possible interactions and will monitor detainees closely for any signs that such interactions are developing. See *id.* at 33-35. This monitoring, along with quick intervention if any signs of problematic symptoms develop, can be expected to prevent a detainee from experiencing severe physical pain.

We also understand that some studies suggest that extended sleep deprivation may be associated with a reduced tolerance for some forms of pain.<sup>9</sup> Several of the techniques used by

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<sup>8</sup> Our advice about wall standing and stress positions assumes that the positions used in each technique are not designed to produce severe pain that might result from contortions or twisting of the body, but only temporary muscle fatigue.

<sup>9</sup> For example, one study found a statistically significant drop of 8-9% in subjects' tolerance thresholds for mechanical or pressure pain after 40 hours of total sleep deprivation. See S. Hakki Onen, et al., *The Effects of Total Sleep Deprivation, Selective Sleep Interruption and Sleep Recovery on Pain Tolerance Thresholds in Healthy Subjects*, 10 J. Sleep Research 35, 41 (2001); see also *id.* at 35-36 (discussing other studies). Another study of extended total sleep deprivation found a significant decrease in the threshold for heat pain and some decrease in the cold pain threshold. See B. Kundermann, et al., *Sleep Deprivation Affects Thermal Pain Thresholds but not Somatosensory Thresholds in Healthy Volunteers*, 66 Psychosomatic Med. 932 (2004).

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the CIA may involve a degree of physical pain, as we have previously noted, including facial and abdominal slaps, walling, stress positions, and water dousing. Nevertheless, none of these techniques would cause anything approaching severe physical pain. Because sleep deprivation appears to cause at most only relatively moderate decreases in pain tolerance, the use of these techniques in combination with extended sleep deprivation would not be expected to cause severe physical pain.

Therefore, the combined use of techniques, as set out in the *Background Paper* and the April 22 [REDACTED] Fax, would not reasonably be expected by the interrogators to result in severe physical pain. We conclude that the authorized use of these techniques in combination by adequately trained interrogators, as you have described it, could not reasonably be considered specifically intended to cause such pain for purposes of sections 2340-2340A. The close monitoring of each detainee for any signs that he is at risk of experiencing severe physical pain reinforces the conclusion that the combined use of interrogation techniques is not intended to inflict such pain. OMS has directed that "[m]edical officers must remain cognizant at all times of their obligation to prevent 'severe physical or mental pain or suffering.'" *OMS Guidelines* at 10. The obligation of interrogation team members and medical staff to intercede if their observations indicate a detainee is at risk of experiencing severe physical pain, and the expectation that all interrogators understand the important role played by OMS and will cooperate with them in the exercise of this duty, are here, as in *Techniques*, essential to our advice. See *Techniques* at 14.

#### *Severe Physical Suffering*

We noted in *Techniques* that, although the statute covers a category of "severe physical ... suffering" distinct from "severe physical pain," this category encompasses only "physical distress that is 'severe' considering its intensity and duration or persistence, rather than merely mild or transitory." *Id.* at 23 (internal quotation marks omitted). Severe physical suffering for purposes of sections 2340-2340A, we have concluded, means a state or condition of physical distress, misery, affliction, or torment, usually involving physical pain, that is both extreme in intensity and significantly protracted in duration or persistent over time. *Id.* Severe physical suffering is distinguished from suffering that is purely mental or psychological in nature, since mental suffering is encompassed by the separately defined statutory category of "severe mental pain or suffering," discussed below. To amount to torture, conduct must be "sufficiently extreme and outrageous to warrant the universal condemnation that the term 'torture' both connotes and invokes." See *Price v. Socialist People's Libyan Arab Jamahiriya*, 294 F.3d 82, 92 (D.C. Cir. 2002) (interpreting the TVPA); cf. *Mehinovic v. Vuckovic*, 198 F. Supp. 2d 1322, 1332-40, 1345-46 (N.D. Ga. 2002) (standard met under the TVPA by a course of conduct that included severe beatings to the genitals, head, and other parts of the body with metal pipes and various other items; removal of teeth with pliers; kicking in the face and ribs; breaking of bones and ribs and dislocation of fingers; cutting a figure into the victim's forehead; hanging the victim and beating him; extreme limitations of food and water; and subjection to games of "Russian roulette").

In *Techniques*, we recognized that, depending on the physical condition and reactions of a given individual, extended sleep deprivation might cause physical distress in some cases. *Id.* at 34. Accordingly, we advised that the strict limitations and safeguards adopted by the CIA are

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important to ensure that the use of extended sleep deprivation would not cause severe physical suffering. *Id.* at 34-35. We pointed to the close medical monitoring by OMS of each detainee subjected to sleep deprivation, as well as to the power of any member of the interrogation team or detention facility staff to intervene and, in particular, to intervention by OMS if OMS concludes in its medical judgment that the detainee may be experiencing extreme physical distress. With those safeguards in place, and based on the assumption that they would be strictly followed, we concluded that the authorized use of sleep deprivation by adequately trained interrogators could not reasonably be considered specifically intended to cause such severe physical suffering. *Id.* at 34. We pointed out that "[d]ifferent individual detainees may react physically to sleep deprivation in different ways," *Id.*, and we assumed that the interrogation team and medical staff "will separately monitor each individual detainee who is undergoing sleep deprivation, and that the application of this technique will be sensitive to the individualized physical condition and reactions of each detainee." *Id.*

Although it is difficult to calculate the additional effect of combining other techniques with sleep deprivation, we do not believe that the addition of the other techniques as described in the *Background Paper* would result in "severe physical . . . suffering." The other techniques do not themselves inflict severe physical pain. They are not of the intensity and duration that are necessary for "severe physical suffering"; instead, they only increase, over a short time, the discomfort that a detainee subjected to sleep deprivation experiences. They do not extend the time at which sleep deprivation would end, and although it is possible that the other techniques increase the physical discomfort associated with sleep deprivation itself, we cannot say that the effect would be so significant as to cause "physical distress that is 'severe' considering its intensity and duration or persistence." *Techniques* at 23 (internal quotation marks omitted). We emphasize that the question of "severe physical suffering" in the context of a combination of techniques is a substantial and difficult one, particularly in light of the imprecision in the statutory standard and the relative lack of guidance in the case law. Nevertheless, we believe that the combination of techniques in question here would not be "extreme and outrageous" and thus would not reach the high bar established by Congress in sections 2340-2340A, which is reserved for actions that "warrant the universal condemnation that the term 'torture' both connotes and invokes." See *Price v. Socialist People's Libyan Arab Jamahiriya*, 294 F.3d at 92 (interpreting the TVPA)

As we explained in *Techniques*, experience with extended sleep deprivation shows that "[s]urprisingly, little seemed to go wrong with the subjects physically. The main effects lay with sleepiness and impaired brain functioning, but even these were no great cause for concern." *Id.* at 36 (quoting James Horne, *Why We Sleep: The Functions of Sleep in Humans and Other Mammals* 23-24 (1988)). The aspects of sleep deprivation that might result in substantial physical discomfort, therefore, are limited in scope; and although the degree of distress associated with sleepiness, as noted above, may differ from person to person, the CIA has found that many of the at least 25 detainees subjected to sleep deprivation have tolerated it well. The general conditions in which sleep deprivation takes place would not change this conclusion. Shackling is employed as a passive means of keeping a detainee awake and is used in a way designed to prevent causing significant pain. A detainee is not allowed to hang by his wrists. When the detainee is shackled in a sitting position, he is on a stool adequate to bear his weight; and if a horizontal position is used, there is no additional stress on the detainee's arm or leg

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joints that might force his limbs beyond their natural extension or create tension on any joint. Furthermore, team members, as well as medical staff, watch for the development of edema and will act to relieve that condition, should significant edema develop. If a detainee subject to sleep deprivation is using an adult diaper, the diaper is checked regularly and changed as needed to prevent skin irritation.

Nevertheless, we recognize, as noted above, the possibility that sleep deprivation might lower a detainee's tolerance for pain. *See supra* p.13 & n.9. This possibility suggests that use of extended sleep deprivation in combination with other techniques might be more likely than the separate use of the techniques to place the detainee in a state of severe physical distress and, therefore, that the detainee might be more likely to experience severe physical suffering. However, you have informed us that the interrogation techniques at issue would not be used during a course of extended sleep deprivation with such frequency and intensity as to induce in the detainee a persistent condition of extreme physical distress such as may constitute "severe physical suffering" within the meaning of sections 2340-2340A. We understand that the combined use of these techniques with extended sleep deprivation is not designed or expected to cause that result. Even assuming there could be such an effect, members of the interrogation team and medical staff from OMS monitor detainees and would intercede if there were indications that the combined use of the techniques may be having that result, and the use of the techniques would be reduced in frequency or intensity or halted altogether, as necessary. In this regard, we assume that if a detainee started to show an atypical, adverse reaction during sleep deprivation, the system for monitoring would identify this development.

These considerations underscore that the combination of other techniques with sleep deprivation magnifies the importance of adhering strictly to the limits and safeguards applicable to sleep deprivation as an individual technique, as well as the understanding that team personnel, as well as OMS medical personnel, would intervene to alter or stop the use of an interrogation technique if they conclude that a detainee is or may be experiencing extreme physical distress.

The waterboard may be used simultaneously with two other techniques: it may be used during a course of sleep deprivation, and as explained above, a detainee subjected to the waterboard must be under dietary manipulation, because a fluid diet reduces the risks of the technique. Furthermore, although the insult slap, abdominal slap, attention grasp, facial hold, walling, water dousing, stress positions, and cramped confinement cannot be employed during the actual session when the waterboard is being employed, they may be used at a point in time close to the waterboard, including on the same day. *See April 22 [REDACTED] Fax at 3.*

In *Techniques*, we explained why neither sleep deprivation nor the waterboard would impose distress of such intensity and duration as to amount to "severe physical suffering," and, depending on the circumstances and the individual detainee, we do not believe the combination of the techniques, even if close in time with other techniques, would change that conclusion. The physical distress of the waterboard, as explained in *Techniques*, lasts only during the relatively short periods during a session when the technique is actually being used. Sleep deprivation would not extend that period. Moreover, we understand that there is nothing in the literature or experience to suggest that sleep deprivation would exacerbate any harmful effects of the waterboard. *See supra* p. 9. Similarly, the use of the waterboard would not extend the time

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of sleep deprivation or increase its distress, except during the relatively brief times that the technique is actually being used. And the use of other techniques that do not involve the intensity and duration required for "severe physical suffering" would not lengthen the time during which the waterboard would be used or increase, in any apparent way, the intensity of the distress it would cause. Nevertheless, because both the waterboard and sleep deprivation raise substantial questions, the combination of the techniques only heightens the difficulty of the issues. Furthermore, particularly because the waterboard is so different from other techniques in its effects, its use in combination with other techniques is particularly difficult to judge in the abstract and calls for the utmost vigilance and care.

Based on these assumptions, and those described at length in *Techniques*, we conclude that the combination of techniques, as described in the *Background Paper* and the April 22 [REDACTED] Fax, would not be expected by the interrogators to cause "severe physical . . . suffering," and that the authorized use of these techniques in combination by adequately trained interrogators could not reasonably be considered specifically intended to cause severe physical suffering within the meaning of sections 2340-2340A.

#### *Severe Mental Pain or Suffering*

As we explained in *Techniques*, the statutory definition of "severe mental pain or suffering" requires that one of four specified predicate acts cause "prolonged mental harm." 18 U.S.C. § 2340(2); see *Techniques* at 24-25. In *Techniques*, we concluded that only two of the techniques at issue here—sleep deprivation and the waterboard—could even arguably involve a predicate act. The statute provides that "the administration or application . . . of . . . procedures calculated to disrupt profoundly the senses or the personality" can be a predicate act. 18 U.S.C. § 2340(2)(B). Although sleep deprivation may cause hallucinations, OMS, supported by the scientific literature of which we are aware, would not expect a profound disruption of the senses and would order sleep deprivation discontinued if hallucinations occurred. We nonetheless assumed in *Techniques* that any hallucinations resulting from sleep deprivation would amount to a profound disruption of the senses. Even on this assumption, we concluded that sleep deprivation should not be deemed "calculated" to have that effect. *Techniques* at 35-36. Furthermore, even if sleep deprivation could be said to be "calculated" to disrupt the senses profoundly and thus to qualify as a predicate act, we expressed the understanding in *Techniques* that, as demonstrated by the scientific literature about which we knew and by relevant experience in CIA interrogations, the effects of sleep deprivation, including the effects of any associated hallucinations, would rapidly dissipate. Based on that understanding, sleep deprivation therefore would not cause "prolonged mental harm" and would not meet the statutory definition for "severe mental pain or suffering." *Id.* at 36.

We noted in *Techniques* that the use of the waterboard might involve a predicate act. A detainee subjected to the waterboard experiences a sensation of drowning, which arguably qualifies as a "threat of imminent death." 18 U.S.C. § 2340(2)(C). We noted, however, that there is no medical basis for believing that the technique would produce any prolonged mental harm. As explained in *Techniques*, there is no evidence for such prolonged mental harm in the CIA's experience with the technique, and we understand that it has been used thousands of times

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(albeit in a somewhat different way) during the military training of United States personnel, without producing any evidence of such harm.

There is no evidence that combining other techniques with sleep deprivation or the waterboard would change these conclusions. We understand that none of the detainees subjected to sleep deprivation has exhibited any lasting mental harm, and that, in all but one case, these detainees have been subjected to at least some other interrogation technique besides the sleep deprivation itself. Nor does this experience give any reason to believe that, should sleep deprivation cause hallucinations, the use of these other techniques in combination with sleep deprivation would change the expected result that, once a person subjected to sleep deprivation is allowed to sleep, the effects of the sleep deprivation, and of any associated hallucinations, would rapidly dissipate.

Once again, our advice assumes continuous, diligent monitoring of the detainee during sleep deprivation and prompt intervention at the first signs of hallucinatory experiences. The absence of any atypical, adverse reaction during sleep deprivation would buttress the inference that, like others deprived of sleep for long periods, the detainee would fit within the norm established by experience with sleep deprivation, both the general experience reflected in the medical literature and the CIA's specific experience with other detainees. We understand that, based on these experiences, the detainee would be expected to return quickly to his normal mental state once he has been allowed to sleep and would suffer no "prolonged mental harm."

Similarly, the CIA's experience has produced no evidence that combining the waterboard and other techniques causes prolonged mental harm, and the same is true of the military training in which the technique was used. We assume, again, continuous and diligent monitoring during the use of the technique, with a view toward quickly identifying any atypical, adverse reactions and intervening as necessary.

The *Background Paper* raises one other issue about "severe mental pain or suffering." According to the *Background Paper*, the interrogators may tell detainees that they "will do what it takes to get important information." *Background Paper* at 10. (We understand that interrogators may instead use other statements that might be taken to have a similar import.) Conceivably, a detainee might understand such a statement as a threat that, if necessary, the interrogators will imminently subject him to "severe physical pain or suffering" or to "the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality," or he perhaps even could interpret the statement as a threat of imminent death (although, as the detainee himself would probably realize, killing a detainee would end the flow of information). 18 U.S.C. § 2340(2)(A)-(C).

We doubt that this statement is sufficiently specific to qualify as a predicate act under section 2340(2). Nevertheless, we do not have sufficient information to judge whether, in context, detainees understand the statement in any of these ways. If they do, this statement at the beginning of the interrogation arguably requires considering whether it alters the detainee's perception of the interrogation techniques and whether, in light of this perception, prolonged mental harm would be expected to result from the combination throughout the interrogation process of all of the techniques used. We do not have any body of experience, beyond the CIA's

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own experience with detainees, on which to base an answer to this question. SERE training, for example, or other experience with sleep deprivation, does not involve its use with the standing position used here, extended nudity, extended dietary manipulation, and the other techniques which are intended "to create a state of learned helplessness," *Background Paper* at 1, and SERE training does not involve repeated applications of the waterboard. A statement that the interrogators "will do what it takes to get important information" moves the interrogations at issue here even further from this body of experience.

Although it may raise a question, we do not believe that, under the careful limitations and monitoring in place, the combined use outlined in the *Background Paper*, together with a statement of this kind, would violate the statute. We are informed that, in the opinion of OMS, none of the detainees who have heard such a statement in their interrogations has experienced "prolonged mental harm," such as post-traumatic stress disorder, *see Techniques* at 26 n.31, as a result of it or the various techniques utilized on them. This body of experience supports the conclusion that the use of the statement does not alter the effects that would be expected to follow from the combined use of the techniques. Nevertheless, in light of these uncertainties, you may wish to evaluate whether such a statement is a necessary part of the interrogation regimen or whether a different statement might be adequate to convey to the detainee the seriousness of his situation.

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In view of the experience from past interrogations, the judgment of medical and psychological personnel, and the interrogation team's diligent monitoring of the effects of combining interrogation techniques, interrogators would not reasonably expect that the combined use of the interrogation methods under consideration, subject to the conditions and safeguards set forth here and in *Techniques*, would result in severe physical or mental pain or suffering within the meaning of sections 2340-2340A. Accordingly, we conclude that the authorized use, as described in the *Background Paper* and the April 22 [REDACTED] Fax, of these techniques in combination by adequately trained interrogators could not reasonably be considered specifically intended to cause severe physical or mental pain or suffering, and thus would not violate sections 2340-2340A. We nonetheless underscore that when these techniques are combined in a real-world scenario, the members of the interrogation team and the attendant medical staff must be vigilant in watching for unintended effects, so that the individual characteristics of each detainee are constantly taken into account and the interrogation may be modified or halted, if necessary, to avoid causing severe physical or mental pain or suffering to any detainee. Furthermore, as noted above, our advice does not extend to combinations of techniques unlike the ones discussed here, and whether any other combination of techniques would be more likely to cause severe physical or mental pain or suffering within the meaning of sections 2340-2340A would be a question that we cannot assess here. Similarly, our advice does not extend to the use of techniques on detainees unlike those we have previously considered; and whether other detainees would, in the relevant ways, be like the ones at issue in our previous advice would be a factual question we cannot now decide. Finally, we emphasize that these are issues about which reasonable persons may disagree. Our task has been made more difficult by the imprecision of the statute and the relative absence of judicial guidance, but we have applied our best reading of the law to the specific facts that you have provided.

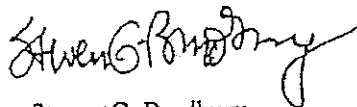
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Please let us know if we may be of further assistance.



Steven G. Bradbury  
Principal Deputy Assistant Attorney General

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